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In the Supreme Court of the United States

OCTOBER TERM, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

ABINGTON MEMORIAL HOSPITAL, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTION PRESENTED

Whether the court of appeals erred in invalidating the regulation of the Secretary of Health and Human Services that established a formula for reimbursing hospitals for the portion of malpractice insurance costs attributable to Medicare patients and in requiring the Secretary to reimburse hospitals according to a prior regulation.

PARTIES TO THE PROCEEDINGS

The petitioners are Margaret M. Heckler, Secretary of Health and Human Services and Carolyne K. Davis, Administrator, Health Care Financing Administration.

The respondents are numerous hospitals and health-care providers in Pennsylvania. They are listed in the margin.*

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* Abington Memorial Hospital, Brandywine Hospital, Bryn Mawr Hospital, Bryn Mawr Rehabilitation Hospital, Columbia Hospital, Ephrata Community Hospital, Germantown Hospital and Medical Center, Graduate Hospital, Holy Redeemer Hospital, Hospital of Philadelphia College of Osteopathic Medicine, Institute of the Pennsylvania Hospital, Jeanes Hospital, Lancaster General Hospital, Lancaster Osteopathic Hospital, Lankenau Hospital, Memorial Hospital-Roxborough, Paoli Memorial Hospital, Pennsylvania Hospital, (The Contributors to the Pennsylvania Hospital, Department for Sick and Injured), Phoenixville Hospital, Presbyterian-University of Pennsylvania Medical Center, Riddle Memorial Hospital, Sacred Heart Hospital, Inc.-Norristown, Sacred Heart General Hospital-Chester, St. Joseph Hospital-Lancaster, Suburban General Hospital-Norristown, Thomas Jefferson University Hospital, Wills Eye Hospital, Friedman Hospital of the Home for the Jewish Aged, Montgomery Hospital, Community General Hospital-Reading, Good Samaritan Hospital-Pottsville, Pottsville Hospital and Warne Clinic, Reading Hospital and Medical Center, Allentown Hospital Association, Allentown Osteopathic Hospital, Easton Hospital, Quakertown Hospital Association, Sacred Heart Hospital-Allentown, Mount Trexler Skilled Nursing Facility of Sacred Hospital-Allentown, Albert Einstein Medical Center, Center City Hospital, Chestnut Hill Hospital, Crozer-Chester Medical Center, Frankford Hospital, Grand View Hospital, Haverford Community Hospital, James C. Giuffre Medical Center, John F. Kennedy Memorial Hospital, Kensington Hospital, Lawndale Community Hospital (MEDIQ, Inc.), Lower Bucks Hospital, Mercy Catholic Medical Center, Methodist Hospital-Philadelphia, Nazareth Hos-

pital, North Penn Hospital, Northwestern Institute of Psychiatry, Pottstown Memorial Medical Center, Rolling Hill Hospital and Diagnostic Center (United Hospitals, Inc.), St. Christopher's Hospital for Children, St. Joseph's Hospital-Philadelphia, St. Mary Hospital-Langhorne, St. Mary Hospital-Philadelphia, Southern Chester County Medical Center, Taylor Hospital, Warminster General Hospital (United Hospitals, Inc.), Memorial Osteopathic Hospital, Philhaven Hospital, Annie M. Warner Hospital, Berwick Hospital Corp., Bloomsburg Hospital, Centre Community Hospital, Community General Osteopathic Hospital, Fulton County Medical Center, Geisinger Medical Center, Good Samaritan Hospital of Lebanon, Hanover General Hospital, Hanover General Hospital-Hillview House, Harrisburg Hospital, Lewistown Hospital, Rehabilitation Hospital for Special Services, Sunbury Community Hospital, Sunbury Skilled Nursing Care Unit, Waynesboro Hospital, York Hospital, Barnes-Kasson County Hospital, Barnes-Kasson Skilled Nursing Facility, Barnes-Kasson Home Health Agency, Bucktail Medical Center, Carbondale General Hospital, Community Medical Center, Divine Providence Hospital-Williamsport, Divine Providence Hospital Skilled Nursing Facility-Williamsport, Gnaden Heutten Memorial Hospital, Gnaden Heutten Nursing and Convalescent Center, Lock Haven Hospital, Memorial Hospital, Inc.-Towanda, Memorial Hospital, Inc. Skilled Nursing Facility-Towanda, Mercy Hospital-Scranton, Mid-Valley Hospital, Montrose General Hospital, Inc., Moses Taylor Hospital, Moses Taylor Skilled Nursing Facility, Pittston Hospital (NPW Medical Center of NE, PA, Inc.), Pocono Hospital, The Robert Parker Hospital, St. Joseph Hospital-Hazelton, Soldiers and Sailors Memorial Hospital, Troy Community Hospital, Inc., Tyler Memorial Hospital, Wayne County Memorial Hospital Association, Wayne County Memorial Skilled Nursing Facility, Wayne County Memorial Hospital Home Health Agency, Williamsport Hospital, Wyoming Valley Hospital (NPW Medical Center of NE PA, Inc.), St. Joseph's Hospital-Carbondale, Charles Cole Memorial Hospital, Charles Cole Memorial Hospital Skilled Nursing Facility, J.C. Blair Memorial Hospital, Allegheny General Hospital, Allegheny Valley Hospital, Aliquippa Hospital, Altoona Hospital, Andrew Kaul Memorial Hospital, Andrew Kaul Memorial Hos-

pital Skilled Nursing Facility, Armstrong County Memorial Hospital, Braddock General Hospital, Bradford Hospital, Brookville Hospital, Brownsville General Hospital, Butler County Memorial Hospital, Central Medical Health Center and Hospital, Clarion Osteopathic Hospital, Clearfield Hospital, Clearfield Home Health Agency, Conemaugh Valley Memorial Hospital, Community Mental Health Center of Beaver County, Corry Memorial Hospital Association, Divine Providence-Pittsburgh, Doctors Osteopathic Hospital, DuBois Hospital, Elk County General Hospital, Ellwood City Hospital, Ellwood City Hospital Skilled Nursing Facility, Eye and Ear Hospital of Pittsburgh, Greene County Memorial Hospital, Greenville Hospital, Hamot Medical Center, Henry Clay Frick Community Hospital, Indiana Hospital, Jameson Memorial Hospital, Keannette District Memorial Hospital, Latrobe Area Hospital, Lee Hospital, Magee-Womens Hospital, McKeesport Hospital, Meadville City Hospital, Memorial Hospital of Bedford County, Mercy Hospital of Johnstown, Mercy Hospital-Pittsburgh, Meyersdale Community Hospital, Miners Hospital of Northern Cambria, Monongahela Valley Hospital, Inc., Montefiore Hospital Ass'n of Western Pennsylvania, Nason Hospital Association, North Hills Passavant Hospital, Ohio Valley General Hospital, Oil City Hospital, Oil City Hospital Skilled Nursing Facility, Podiatry Hospital of Pittsburgh, Port Allegany Community Hospital, Presbyterian-University Hospital, Punxsutawney Area Hospital, Sewickley Valley Hospital, Shadyside Hospital, Sharon General Hospital, Shenango Valley Osteopathic Hospital, Somerset Community Hospital, South Hills Health System Home Health Agency, South Hills Health System, South Hills Health System Skilled Nursing Facility, South Side Hospital of Pittsburgh, Spencer Hospital, St. Clair Memorial Hospital, St. Francis Hospital-New Castle, St. Francis General Hospital-Pittsburgh, St. Francis General Hospital Skilled Nursing Facility, St. Francis General Hospital Home Health Agency, St. John's General Hospital, St. Margaret Memorial Hospital-Pittsburgh, St. Vincent Health Center, Suburban General Hospital-Pittsburgh, Tyrone Hospital, Union City Memorial Hospital, Uniontown Hospital, Warren General Hospital, Washington Hospital, West Allegheny Hospital, Westmoreland Hospital Assoc., West Penn Hospital, Western Psychiatric Institute and Clinic, Windber Hospital and Wheeling Clinic.

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v.

ABINGTON MEMORIAL HOSPITAL, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

The Acting Solicitor General, on behalf of the Secretary of Health and Human Services, *et al.*, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-10a) is reported at 750 F.2d 242. The opinion of the district court (App., *infra*, 11a-28a) is reported at 576 F. Supp. 1081.

JURISDICTION

The judgment of the court of appeals (App., *infra*, 29a-30a) was entered on December 13, 1984. A petition for rehearing was denied on February 14, 1985

(App., *infra*, 31a-33a)). On May 7, 1985, Justice Brennan extended the time for filing a petition for a writ of certiorari to June 14, 1985. On June 3, 1985, Justice Brennan further extended the time for filing a petition for a writ of certiorari to July 14, 1985. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTE INVOLVED

Title XVIII of the Social Security Act requires the Federal Hospital Insurance Trust Fund to reimburse hospitals for services provided to Medicare patients. 42 U.S.C. 1395g(a). The Act limits Medicare reimbursement to the lesser of the "reasonable cost" or "customary charges" for these services. 42 U.S.C. 1395f(b)(1). The Act defines "reasonable cost" as follows (42 U.S.C. 1395x(v)(1)(A)):

> The reasonable cost of any services shall be the cost actually incurred, * * * and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs * * *. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular

> items or services * * *, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services * * * in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

STATEMENT

This case arises in the context of ongoing efforts of the Secretary of Health and Human Services to comply with dual prongs of a statutory obligation which has proved unusually difficult to implement. As we discuss, those efforts are now going forward in a new rulemaking proceeding.

1. In 1965, Congress amended the Social Security Act to add Title XVIII, creating a federal medical insurance program for the elderly (Medicare Act). 42 U.S.C. 1395 *et seq.*[1] Participating providers of health care services (principally hospitals and skilled-care nursing homes) are reimbursed for services to Medicare patients out of the Federal Hospital Insurance Trust Fund, which is funded by Social Security tax revenues. 42 U.S.C. 1395g(a), 1395i.

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[1] The Medicare Act was amended in 1972 to add coverage of certain disabled persons. 42 U.S.C. 1395c, 1395o.

The Medicare Act authorizes the Secretary of Health and Human Services to reimburse hospitals for their "reasonable cost", both direct and indirect, of providing services to Medicare-insured patients.[2] 42 U.S.C. 1395f(b)(1). Subject to a number of qualifications, the Act defines "reasonable cost" as "the cost actually incurred," and authorizes the Secretary to promulgate "regulations establishing the method or methods to be used, and the items to be included, in determining such costs * * *." 42 U.S.C. 1395x(v)(1)(A). Under the Act, the Secretary's regulations defining "reasonable cost" (*ibid.*):

> may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, [and] may provide for using different methods in different circumstances * * *.

The Act further directs the Secretary to define "reasonable cost" in a way that prevents cost-shifting between Medicare and non-Medicare patients. Medicare costs may not be borne by non-Medicare patients, and "costs with respect to [non-Medicare patients] will not be borne by [the Medicare] programs * * *." *Ibid.*

2. At the outset of the Medicare program, the Secretary chose to satisfy this dual statutory mandate by reimbursing malpractice insurance premiums according to a general formula used for all overhead costs. 31 Fed. Reg. 14808 (1966). Under this formula, hospital overhead expenses, designated "general and administrative" (G&A) costs, were al-

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[2] The Medicare Act has recently been amended to provide that after 1986 most hospitals will be reimbursed under a prospective payment system, not the reasonable cost system. See 42 U.S.C. 1395ww.

located to the hospital's revenue-producing cost centers (*e.g.*, operating room or emergency room) and then apportioned to Medicare and non-Medicare patients according to the utilization of the cost center by each category of patient, as measured by patient charges. C.A. App. 76-77. For example, under this "patient utilization" formula, if 35% of the patient charges in the operating room were for Medicare patients, then 35% of the overhead expenses allocated to the operating room would be reimbursed by Medicare.

The precipitous rise in malpractice insurance costs in the early 1970's occasioned an administrative review of the area. In contrast to the situation that existed when the Medicare reimbursement regulations were issued in 1966, within the next decade malpractice premiums rose sharply and became "a large part of hospital budgets." Adm. Rec. Vol. 5 (comments of Ancilla Domini Health Services at 2); 44 Fed. Reg. 31641 (1979). The Secretary eventually concluded that application of the existing "patient utilization" formula to malpractice insurance costs no longer conformed to the second prong of the statutory directive: that Medicare funds not subsidize the costs of non-Medicare patients. The Secretary noted that the average recovery by Medicare patients in malpractice suits is smaller than that of non-Medicare patients, since Medicare patients are usually elderly, and life expectancy and earnings potential are significant elements in malpractice awards. *Ibid.* Accordingly, the evidence before the Secretary indicated that Medicare patients received smaller payments on malpractice claims. Adm. Rec. Vol. 3 (Medical Malpractice Closed Claim Study at 5-10). Since Medicare patients represented smaller

per capita exposure than other patients, the "patient utilization" approach to apportioning the costs of malpractice premiums, which did not account for this significant discrepancy in a major reimbursable cost, was inconsistent with the Secretary's statutory obligation. 44 Fed. Reg. 31642 (1979).

After notice and public comment (see 44 Fed. Reg. 15744 (1979)), the Secretary issued the regulation challenged in this case. 44 Fed. Reg. 31642 (1979); App., *infra*, 34a-42a. The new rule removes malpractice insurance premiums from the undifferentiated pool of G&A costs because (1) "malpractice costs are so significant" and (2) "the disproportionate allocation of malpractice costs to Medicare is so great." *Ibid.* Under this rule, a hospital's malpractice premiums for each cost year are allocated to Medicare according to the hospital's actual malpractice loss experience (the ratio of Medicare-patient malpractice claims paid to total claims paid for the year in question and the previous four years). 44 Fed. Reg. 31642 (1979), promulgating 42 C.F.R. 405.452(b) (later recodified as 42 C.F.R. 405.452(a)(ii)). In the case of hospitals with no paid claims during this five-year period, reimbursement is made according to the national ratio of paid Medicare-patient malpractice claims to total paid claims, which the Secretary computed at 5.1%. App., *infra*, 36a.

3. Following issuance of the new "paid claims" rule, hospitals all over the country contested the rule in proceedings before the Provider Reimbursement Review Board (PRRB).[3] The PRRB then issued the

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[3] Under the Medicare Act, the proper level of hospital reimbursement is first determined for the Secretary by a so-called "fiscal intermediary" (such as Blue Cross). The hospitals may then appeal to the PRRB. When proceedings before

appropriate certifications under 42 U.S.C. 1395oo (f)(1), following which suits were brought in numerous district courts around the country.[4] To date, there have been 26 district court decisions (in addition to the decision below); of which 6 have upheld the rule[5] and 20 have invalidated it on various grounds.[6] There have been decisions by the courts

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the PRRB involve an issue of the validity of a Medicare regulation, a matter over which the PRRB has no jurisdiction, the Board may so certify, following which the hospital may bring suit in a United States district court. 42 U.S.C. 1395oo(f)(1).

[4] Suits have been brought in district courts in every circuit except the First.

[5] *Athens Community Hospital* v. *Heckler*, 565 F. Supp. 695 (E.D. Tenn. 1983); *Cumberland Medical Center* v. *Heckler*, 578 F. Supp. 39 (M.D. Tenn. 1983); *Benton County General Hospital* v. *Heckler*, Civ. No. 82-1289 (W.D. Tenn. Oct. 25, 1983); *Humana of Aurora, Inc. d/b/a Aurora Community Hospital* v. *Heckler*, Civ. No. 83-Z-70 (D. Colo. Sept. 25, 1983), rev'd, 753 F.2d 1579 (10th Cir. 1985); *Walter O. Boswell Memorial Hospital* v. *Heckler*, 573 F. Supp. 884 (D.D.C. 1983), remanded, 749 F.2d 788 (D.C. Cir. 1984); *Normandy Osteopathic-North Hospital* v. *Heckler*, Civ. No. 83-1687C(1) (E.D. Mo. Dec. 21, 1984).

[6] *Mt. Carmel Mercy Hospital* v. *Heckler*, 581 F. Supp. 1311 (E.D. Mich. 1983); *Chelsea Community Hospital* v. *Heckler*, Civ. No. 83-6126-AA (E.D. Mich. Dec. 20, 1983); *Albany General Hospital* v. *Heckler*, 584 F. Supp. 614 (D. Ore. 1984); *St. James Hospital* v. *Heckler*, 579 F. Supp. 757 (N.D. Ill. 1984); aff'd, Nos. 84-1478, 84-1727 (7th Cir. Apr. 8, 1985); *Humana of Illinois, Inc. d/b/a Springfield Community Hospital* v. *Heckler*, 584 F. Supp. 618 (C.D. Ill. 1984), aff'd, Nos. 84-1478, 84-1727 (7th Cir. Apr. 18, 1985); *Bedford County Memorial Hospital* v. *Heckler*, 583 F. Supp. 367 (W.D. Va. 1984); *Alexandria Hospital* v. *Heckler*, 586 F. Supp. 581 (E.D. Va. 1984); *Lloyd Noland Hospital and Clinic* v. *Heckler*, Civ. No. 83-PT-0868-S (N.D. Ala. Apr. 6, 1984), aff'd, Nos. 84-7444, 84-8699 (11th Cir. June 12, 1985); *Metropolitan Hospital, Inc.* v. *Heckler*, Civ. No. C83-502A (N.D. Ga.

of appeals in the District of Columbia, Third, Fifth, Seventh, Tenth and Eleventh Circuits.[7] The District of Columbia Circuit noted that the new rule is a "fair formulation of HHS's statutory mandate," 749 F.2d at 802, but remanded the case for consideration of the entire administrative record. The other courts of appeals have held the new rule invalid on one or more grounds.

The present case arose from suits filed by various hospitals in the Eastern, Middle and Western Districts of Pennsylvania, that were eventually consolidated in the Eastern District. Respondents had re-

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June 25, 1984), aff'd, Nos. 84-7444, 84-8699 (11th Cir. June 12, 1985); *Parkway Medical Center, et al.* v. *Heckler,* Civ. Nos. 83-1005, 83-1700 (S.D. Fla. Sept. 24, 1984); *DeSoto General Hospital* v. *Heckler,* Civ. No. 83-1050-B (M.D. La. June 22, 1984), aff'd, No. 84-3577 (5th Cir. July 5, 1985); *East Jefferson General Hospital* v. *Heckler,* Civ. No. 83-4107-C (E.D. La. Oct. 19, 1984); *Menorah Medical Center* v. *Heckler,* Civ. No. 83-0822-CV-W-4 (W.D. Mo. July 26, 1984); *Mercy Medical Center and Unity Medical Center* v. *Heckler,* Civ. No. 3-82-Civ. 1724 (D. Minn. Aug. 17, 1984); *Sisters of St. Mary, et al.* v. *Heckler,* Civ. Nos. 83-0789C(4), 83-1604C (C) (E.D. Mo. Nov. 6, 1984); *Arkansas Methodist Hospital, et al.* v. *Heckler,* Civ. Nos. J-C-83-106, J-C-83-148 (E.D. Ark. Nov. 1, 1984); *St. Anthony Regional Hospital, et al.* v. *Heckler,* Civ. No. C-84-37 (N.D. Iowa Oct. 12, 1984); *Marshalltown Area Community Hospital* v. *Heckler,* Civ. No. 84-226-B (S.D. Iowa Dec. 17, 1984); *Bethesda Hospital* v. *Heckler,* Civ. No. C-1-83-622 (S.D. Ohio Apr. 30, 1985); *St. Joseph's Hospital* v. *Heckler,* 583 F. Supp. 1545 (D. Ariz. 1984).

[7] In addition to the present decision, the court of appeals decisions are: *Walter O. Boswell Memorial Hospital* v. *Heckler,* 749 F.2d 788 (D.C. Cir. 1984); *St. James Hosptial* v. *Heckler,* Nos. 84-1478, 84-1727 (7th Cir. Apr. 18, 1985); *Humana of Aurora, Inc.* v. *Heckler,* 753 F.2d 1579 (10th Cir. 1985); *Lloyd Noland Hospital and Clinic* v. *Heckler,* Nos. 84-7444, 84-8699 (11th Cir. June 12, 1985); *DeSoto General Hospital* v. *Heckler,* No. 84-3577 (5th Cir. July 5, 1985).

ceived reimbursement under the new rule for the year ended June 30, 1980, and sought instead to be reimbursed for that year under the prior standard. The amount directly at issue in these suits (*i.e.*, the difference between reimbursement under the old and new formulas for the 1980 cost year) is approximately $6.7 million.

The district court held that the rule was invalid under the Administrative Procedure Act (APA) and the Medicare Act (App., *infra*, 27a). Under the APA, the court held that the statement of basis and purpose was inadequate because it failed to respond adequately to several points raised in the comments, including challenges to the statistical validity of the data upon which the Secretary relied (*id.* at 17a-19a). The court also held that the rule was arbitrary and capricious because of the statistical inadequacy of the data (*id.* at 19a-21a). Under the Medicare Act, the district court held the rule invalid on the grounds that it could lead to "bizarre" results; that malpractice premiums are designed not only to cover losses but also to cover administrative expenses unrelated to amounts paid claimants (such as claims handling expense); that malpractice insurance benefits all patients equally because it is required by law and it protects the hospital's ability to stay in business; and that the Medicare-to-total-claims ratio of an individual hospital, as well as the national ratio of 5.1%, have "very little, if any, relationship to the hospital's current cost of maintaining malpractice protection" (*id.* at 21a-27a).

The court of appeals affirmed, adopting the opinion of the district court (App., *infra*, 1a-10a). The court of appeals also held that the appropriate remedy was a remand to the PRRB with directions to award reimbursement according to the old "patient

utilization" formula. The court held that invalidation of the Secretary's new reimbursement formula left the prior formula in effect, and thus payment under the prior formula was required. The court rejected the Secretary's contention that the remand should allow further rulemaking proceedings (*id.* at 9a-10a).

4. On June 17, 1985, following the decision of the court of appeals, the Secretary published a notice in the Federal Register initiating new rulemaking proceedings. 50 Fed. Reg. 25178. The notice proposes to maintain the paid-claims formula as the basic rule; however, on the basis of more recent data it would increase the "national ratio" (used to calculate reimbursement of hospitals with no paid claims experience) from 5.1% to 11.6%. Both provisions would be applied retroactively to July 1, 1979.[8] 50 Fed. Reg. at 25187, 25188. The Secretary's new proposal contains an extensive discussion of data not available when the paid-claims formula was originally proposed—*i.e.*, cost reports filed by hospitals in connection with claims for reimbursement for cost years ending January 1, 1982 to September 29, 1983. Since these reports include malpractice payment data for the four previous cost years, this new data base covers a five-year period ending in 1983. 50 Fed. Reg. at 25179-25181.

REASONS FOR GRANTING THE PETITION

This case presents a question of great practical importance to the public fisc and to the evenhanded administration of a major federal program. In HHS's estimation, for the period from July 1, 1979 to October 1, 1986,[9] the application to all providers

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[8] See note 13, *infra*.

[9] See note 2, *supra*.

of the former patient-utilization rule instead of the paid-claims rule would increase federal expenditures by $370 million dollars. Although the rule currently under consideration by the Secretary would (if promulgated and upheld by the courts) reduce that economic impact, the judgment below, unless vacated, would cost almost $7 million. Moreover, if the decision below remains intact, respondents would reap an unwarranted windfall—they would be reimbursed for cost year 1980 under the old formula, while all other providers would be reimbursed for all relevant years under the new formula HHS is now in the process of issuing.

The decision below also poses a troublesome administrative law issue. In addition to invalidating the paid-claims rule, the court of appeals required the Secretary to reimburse respondents under the former patient-utilization rule that the Secretary concluded no longer complies with the statutory mandate. Yet the court of appeals did not evaluate the validity of the prior rule; nor did it afford the Secretary an opportunity to cure the defects the court perceived in the new rule.[10]

While these issues are of sufficient importance to warrant this Court's review, this is not the optimal moment for their plenary consideration. The pendency of a new rulemaking proceeding that is anticipated to conclude before this case could be heard and decided on the merits indicates that a more appropriate course would be to grant the petition for a writ of certiorari, vacate the judgment below, and remand for reconsideration by the court of appeals

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[10] The district court stated (App., *infra*, 27a) that "the previous utilization rate method of allocation is not the only possible method * * *."

in light of the soon-to-be-issued regulation. In that way the legal issues will be framed more precisely and concretely for judicial scrutiny in light of the new regulation, and this Court would not be required to address the validity of that regulation in the first instance.

1. The Medicare Act's definition of "reasonable costs" poses a practical dilemma for the Secretary. The requirement that the actual, necessary costs of services to Medicare patients be reimbursed, coupled with the prohibition of payment for services to non-Medicare patients, presents a knotty regulatory problem. The problem is particularly acute when overhead, or G&A, costs are to be allocated. While the patient utilization formula was an appropriate response in 1966, the subsequent explosion in malpractice insurances costs brought imbalance to the cost equation. The Secretary's response recognized that a difference existed between the malpractice claims experience of Medicare and non-Medicare patients. In seeking to fashion a rule that more accurately reflected the source of malpractice insurance costs, the Secretary acted with fidelity to the statutory prohibition against reimbursement of costs generated by non-Medicare patients.

Medicare patients are by definition either disabled or elderly and it was neither arbitrary nor capricious for the Secretary to conclude that these conditions would affect the life-expectancy and earnings-potential components of malpractice awards. The Secretary's authority under the Medicare Act to determine Medicare patient costs on a "per unit, per capita, or other basis" and to use "different methods in different circumstances" grants her substantial latitude. 42 U.S.C. 1395x(v)(1)(A). Thus, the Act empow-

ers the Secretary to conclude, if circumstances warrant, that a basis other than per capita allocation is warranted in the malpractice insurance context, and that the reduced exposure generated by Medicare patients justifies a formula that seeks more accurately to distinguish the costs of insuring services to those patients from those to younger, non-disabled patients. "To uphold [the Secretary's regulation] 'we need not find that [its] construction is the only reasonable one, or even that it is the result we would have reached had the question arisen in the first instance in judicial proceedings.' We need only conclude that it is *a* reasonable interpretation of the relevant provisions." *American Paper Institute, Inc.* v. *American Electric Power Service Corp.*, 461 U.S. 402, 422-423 (1983) (emphasis in original; citations omitted), quoting *Unemployment Compensation Comm'n* v. *Aragon*, 329 U.S. 143, 153 (1946); *Aluminum Co. of America* v. *Central Lincoln Peoples' Utility District*, No. 82-1071 (June 5, 1984), slip op. 8-9; see *Mourning* v. *Family Publications Service, Inc.*, 411 U.S. 356, 371-372 (1973). Under the governing authorities, the court of appeals should have accorded deference to the Secretary's effort to comply with her dual statutory mandate.

2. In invalidating the Secretary's implementation of her authority, the court of appeals relied on (1) the Administrative Procedure Act and (2) the Medicare Act. Since the new rulemaking the Secretary has initiated will produce a new record and a new statement of basis and purpose, the procedural issues raised by the prior record are not of continuing significance.

However, unless vacated by this Court, the Third Circuit's interpretation of the Medicare Act would be relevant to the new rulemaking proceeding and

thus would have continuing significance. In two important respects, this interpretation is inconsistent with the interpretation adopted by another court of appeals. First, the Third Circuit adopted the district court's holding that the Act requires the reimbursement formula to take into account the hospital's Medicare patient utilization rate, since a formula that takes no account of that rate can lead to "bizarre" results in individual cases (App., *infra* 6a, 21a). By contrast, in *Walter O. Boswell Memorial Hospital* v. *Heckler*, 749 F.2d 788 (D.C. Cir. 1984), the District of Columbia Circuit accepted the Secretary's contention that the new formula will "result in a fair division of the long-run average" despite "superficially peculiar" short-run results. 749 F.2d at 801, 802.[11] This Court, too, has recognized that in large government programs, "rough accommodations" are justified, if not required. *Weinberger* v. *Salfi*, 422 U.S. 749, 769 (1975), quoting *Dandridge* v. *Williams*, 397 U.S. 471, 485 (1970), and *Metropolis Theatre Co.* v. *City of Chicago*, 228 U.S. 61, 69 (1913).

The courts below concluded also that the Secretary's formula must reflect to some degree the manner in which insurance companies establish premiums (App. *infra*, 24a). In contrast, the District of Columbia

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[11] The Seventh Circuit in *St. James Hospital* v. *Heckler*, Nos. 84-1478, 84-1727 (Apr. 18, 1985), slip op. 22-23, agreed with the courts below that the possibility of unreasonable results in particular cases establishes that the paid claims reimbursement formula violates the Medicare Act. But see *DeSoto General Hospital* v. *Heckler*, No. 84-3577 (5th Cir. July 5, 1985), slip op. 11 (Garza, J., concurring) ("the Secretary is on the right track and I encourage the Secretary to pursue a legitimate study under which a malpractice rule can be issued. I am convinced that [M]edicare patients account for much less of the losses suffered by hospitals in malpractice suits against them * * *").

Circuit concluded in *Boswell* that "the Medicare Act plainly contemplates instances in which the Secretary does not agree with an insurer's definition of actual costs." 749 F.2d at 801.[12]

These questions may eventually have to be resolved by this Court. We are, however, chary of suggesting that they presently are ripe for plenary review. The issues involved should be considerably sharpened by the pending rulemaking, in which the Secretary can build on the experience of judicial criticism of the 1979 rule and react to comments. When that process is complete, the courts below—and this Court if necessary—will have a much better basis for assessing all issues concerning the relationship of malpractice losses to malpractice premiums, and the adequacy of a formula utilizing malpractice loss experience under the "reasonable cost" standard of the Medicare Act. 42 U.S.C. 1395x(v)(1)(A).

Accordingly, we submit that it would be appropriate for this case to be remanded to the court of appeals for it (or if it prefers, the district court) to reconsider the matter in light of the rule currently under consideration. That course would promote judicial economy and adhere to governing law. It is

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[12] The Tenth Circuit in *Humana of Aurora, Inc.* v. *Heckler*, 753 F.2d 1579 (1985), held that the paid-claims formula is arbitrary and capricious partly on the ground that malpractice losses are not the only basis from which malpractice premiums are derived. 753 F.2d at 1582. Similarly, the Seventh Circuit held the paid-claims formula arbitrary and capricious because the Secretary "failed to ascertain the extent of the correlation, if any, between actual malpractice losses and premium costs." *St. James Hospital* v. *Heckler*, Nos. 84-1478, 84-1727 (Apr. 18, 1985), slip op. 14-15. Of course, the government is not bound by the accounting method insurers or respondents have established for their own purposes. Cf. *Exxon Corp.* v. *Department of Revenue*, 447 U.S. 207, 221-223 (1980).

"the guiding principle" of administrative law that "the function of the reviewing court ends when an error of law is laid bare. At that point the matter once more goes to the [agency] for reconsideration." *Federal Power Comm'n* v. *Idaho Power Co.*, 344 U.S. 17, 20 (1952). This Court has stated that on remand the agency is not required to apply the prior rule, but rather to reconsider the entire matter. *Burlington Northern, Inc.* v. *United States*, 459 U.S. 131 (1982); *Motor Vehicle Mfrs. Ass'n* v. *State Farm Mutual Automobile Ins. Co.*, 463 U.S. 29, 40, 57 & n.21 (1983). See also *Richardson* v. *Wright*, 405 U.S. 208 (1972). In contrast, the court below obligated the Secretary to reimburse respondents under the prior patient-utilization formula, providing no opportunity for the Secretary to exercise her statutory authority to promulgate suitable malpractice premium reimbursement rules.

Remand is appropriate also because it is anticipated that by the time this Court could hear the case on the merits, a new rule will have been issued. An appellate court must apply the law in effect at the time it renders its decision. *Gulf Offshore Co.* v. *Mobil Oil Corp.*, 453 U.S. 473, 486 n.16 (1981); *Bradley* v. *Richmond School Board*, 416 U.S. 696, 711 (1974); *Thorpe* v. *Housing Authority*, 393 U.S. 268, 281-283 (1969); *United States* v. *Schooner Peggy*, 5 U.S. (1 Cranch) 103, 110 (1801). Thus, the newly-issued rule would establish the measure of reimbursement and the basis for decision in this case and yet, that rule would not have been the subject of scrutiny by the lower courts.[13] Rather than have this be the

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[13] The Secretary is authorized to make "suitable retroactive corrective adjustments" where the reimbursement produced by the present formula is "inadequate or excessive." 42 U.S.C.

initial forum in which the validity of the new rule is litigated, prudence suggests that the issue be presented first to the lower courts.[14] In that way, if consideration of the issues by this Court is ultimately warranted, it could proceed after proper honing of the issues and on the basis of a complete record (including the pending rulemaking proceeding). Moreover, the disposition we propose would also avoid the unfairness that would result if respondents obtained reimbursement for cost year 1980 based on a formula not applicable to other providers and not applicable to any time period since July 1, 1979. Proper administration of this important federal program requires that the Secretary's resolution of its dual statutory mandate be applied evenhandedly to all providers.

1395x(v)(1)(A)(ii). See *Adams Nursing Home, Inc.* v. *Mathews*, 548 F.2d 1077 (1st Cir. 1977); 42 U.S.C. 1395hh. Thus, a finding by the Secretary in the new rulemaking proceeding that the patient-utilization formula provides "excessive" reimbursement would, under the Act, require retroactive adjustment of prior reimbursement payments. Such adjustments would not be unfair; hospitals have known since 1979 that the Secretary had supplanted the patient-utilization formula.

[14] Should this Court disagree and conclude that the matter is presently ripe for review, then the petition for a writ of certiorari should be granted and the case set for briefing and argument.

CONCLUSION

The petition for a writ of certiorari should be granted, the judgment of the court of appeals vacated, and the case remanded for further proceedings.

Respectfully submitted.

LAWRENCE G. WALLACE
Acting Solicitor General *

RICHARD K. WILLARD
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JULY 1985

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* Acting Solicitor General Fried is disqualified in this case.

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 84-1079

ABINGTON MEMORIAL HOSPITAL, Brandywine Hospital, Bryn Mawr Hospital, Bryn Mawr Rehabilitation Hospital, Columbia Hospital, Ephrata Community Hospital, Germantown Hospital and Medical Center, Graduate Hospital, Holy Redeemer Hospital, Hospital of Philadelphia College of Osteopathic Medicine, Institute of the Pennsylvania Hospital, Jeanes Hospital, Lancaster General Hospital, Lancaster Osteopathic Hospital, Lankenau Hospital, Memorial Hospital-Roxborough, Paoli Memorial Hospital, Pennsylvania Hospital, (The Contributors to the Pennsylvania Hospital, Department for Sick and Injured), Phoenixville Hospital, Presbyterian-University of Pennsylvania Medical Center, Riddle Memorial Hospital, Sacred Heart Hospital, Inc.-Norristown, Sacred Heart General Hospital-Chester, St. Joseph Hospital-Lancaster, Suburban General Hospital-Norristown, Thomas Jefferson University Hospital, Wills Eye Hospital. Friedman Hospital of the Home for the Jewish Aged, Montgomery Hospital, Community General Hospital-Reading, Good Samaritan Hospital-Pottsville, Pottsville Hospital and Warne Clinic, Reading Hospital and Medical Center, Allentown Hospital Association, Allentown Osteopathic Hospital, Easton Hospital, Quakertown Hospital Association, Sacred

Heart Hospital-Allentown, Mount Trexler Skilled Nursing Facility of Sacred Heart Hospital-Allentown, Albert Einstein Medical Center, Center City Hospital, Chestnut Hill Hospital, Crozer-Chester Medical Center, Frankford Hospital, Grand View Hospital, Haverford Community Hospital, James C. Giuffre Medical Center, John F. Kennedy Memorial Hospital, Kensington Hospital, Lawndale Community Hospital (MEDIQ, Inc.), Lower Bucks Hospital, Mercy Catholic Medical Center, Methodist Hospital-Philadelphia, Nazareth Hospital, North Penn Hospital, Northwestern Institute of Psychiatry, Pottstown Memorial Medical Center, Rolling Hill Hospital and Diagnostic Center (United Hospitals, Inc.), St. Christopher's Hospital for Children, St. Joseph's Hospital-Philadelphia, St. Mary Hospital-Langhorne, St. Mary Hospital-Philadelphia, Southern Chester County Medical Center, Taylor Hospital, Warminster General Hospital (United Hospitals, Inc.)

vs.

HECKLER, MARGARET M., Secretary of the Department of Health and Human Services and DAVIS, CAROLYNE K., Administrator Health Care Financing Administration

(D.C. Civil 82-2856)

MEMORIAL OSTEOPATHIC HOSPITAL, Philhaven Hospital, Annie M. Warner Hospital, Berwick Hospital Corp., Bloomsburg Hospital, Centre Community Hospital, Community General Osteopathic Hospital, Fulton County Medical Center, Geisinger Medical Center, Good Samaritan Hospital of Lebanon, Hanover General Hospital, Hanover General Hospital-Hillview House, Harrisburg Hospital, Lewis-

town Hospital, Rehabilitation Hospital for Special Services, Sunbury Community Hospital, Sunbury Skilled Nursing Care Unit, Waynesboro Hospital, York Hospital, Barnes-Kasson County Hospital, Barnes-Kasson Skilled Nursing Faciilty, Barnes-Kasson Home Health Agency, Bucktail Medical Center, Carbondale General Hospital, Community Medical Center, Divine Providence Hospital-Williamsport, Divine Providence Hospital Skilled Nursing Facility-Williamsport, Gnaden Heutten Memorial Hospital, Gnaden Heutten Nursing and Convalescent Center, Lock Haven Hospital, Memorial Hospital, Inc.-Towanda, Memorial Hospital, Inc. Skilled Nursing Facility-Towanda, Mercy Hospital-Scranton, Mid-Valley Hospital, Montrose General Hospital, Inc., Moses Taylor Hospital, Moses Taylor Skilled Nursing Facility, Pittston Hospital (NPW Medical Center of NE PA, Inc.), Pocono Hospital, The Robert Parker Hospital, St. Joseph Hospital-Hazleton, Soldiers and Sailors Memorial Hospital, Troy Community Hospital, Inc., Tyler Memorial Hospital, Wayne County Memorial Hospital Association, Wayne County Memorial Skilled Nursing Facility, Wayne County Memorial Hospital Home Health Agency, Williamsport Hospital, Wyoming Valley Hospital (NPW Medical Center of NE PA, Inc.), St. Joseph's Hospital-Carbondale, Charles Cole Memorial Hospital, Charles Cole Memorial Hospital Skilled Nursing Faciilty, J.C. Blair Memorial Hospital

vs.

HECKLER, MARGARET M., SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

and

DAVIS, CAROLYNE K., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

(D.C. Civil 82-3465)

ALLEGHENY GENERAL HOSPITAL, Allegheny Valley Hospital, Aliquippa Hospital, Altoona Hospital, Andrew Kaul Memorial Hospital, Andrew Kaul Memorial Hospital Skilled Nursing Facility, Armstrong County Memorial Hospital, Braddock General Hospital, Bradford Hospital, Brookville Hospital, Brownsville General Hospital, Butler County Memorial Hospital, Central Medical Health Center and Hospital, Clarion Osteopathic Hospital, Clearfield Hospital, Clearfield Home Health Agency, Conemaugh Valley Memorial Hospital, Community Mental Health Center of Beaver County, Corry Memorial Hospital Association, Divine Providence-Pittsburgh, Doctors Osteopathic Hospital, DuBois Hospital, Elk County General Hospital, Ellwood City Hospital, Ellwood City Hospital Skilled Nursing Facility, Eye and Ear Hospital of Pittsburgh, Greene County Memorial Hospital, Greenville Hospital, Hamot Medical Center, Henry Clay Frick Community Hospital, Indiana Hospital, Jameson Memorial Hospital, Keannette District Memorial Hospital, Latrobe Area Hospital, Lee Hospital, Magee-Womens Hospital, McKeesport Hospital, Meadville City Hospital, Memorial Hospital of Bedford County, Mercy Hospital of Jamestown, Mercy Hospital-Pittsburgh, Meyersdale Community Hospital, Miners Hospital of Northern Cambria, Monongahela Valley Hospital, Inc., Montefiore Hospital Assn. of Western Pennsylvania, Nason Hospital Association, North Hills Passavant Hospital, Ohio Valley General Hospital, Oil City Hospital, Oil

City Hospital Skilled Nursing Facility, Podiatry Hospital of Pittsburgh, Port Allegany Community Hospital, Presbyterian-University Hospital, Punxsutawney Area Hospital, Sewickley Valley Hospital, Shadyside Hospital, Sharon General Hospital, Shenango Valley Osteopathic Hospital, Somerset Community Hospital, South Hills Health System Home Health Agency, South Side Hospital of Pittsburgh, Spencer Hospital, St. Clair Memorial Hospital, St. Francis Hospital-New Castle, St. Francis General Hospital-Pittsburgh, St. Francis General Hospital Skilled Nuring Facility, St. Francis General Hospital Home Health Agency, St. John's General Hospital, St. Margaret Memorial Hospital-Pittsburgh, St. Vincent Health Center, Suburban General Hospital-Pittsburgh, Tyrone Hospital, Union City Memorial Hospital, Uniontown Hospital, Warren General Hospital, Washington Hospital, West Allegheny Hospital, Westmoreland Hospital Assoc., West Penn Hospital, Western Psychiatric Institute and Clinic, Windber Hospital and Wheeling Clinic

vs.

HECKLER, MARGARET M., SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

and

DAVIS, CAROLYN K., ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION

(D.C. Civil 82-3640)

MARGARET M. HECKLER, ET AL., APPELLANTS

Appeal from the United States District Court
for the Eastern District of Pennsylvania
D.C. Nos. 82-2856, 82-3465, 82-3640

Opinion filed December 13, 1984

OPINION OF THE COURT

Before: HUNTER, WEIS, *Circuit Judges*,
and COHEN,* *District Judge*

HUNTER. *Circuit Judge:*

1. This appeal arises from an order invalidating a regulation promulgated under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* (1982) ("the Medicare Act"). The regulation in question governs the reimbursement of malpractice insurance premiums associated with the care of Medicare patients to health-care providers. 42 C.F.R. § 405.452 (a) (1) (ii) (1983) ("The Malpractice Rule"). Subject matter jurisdiction in this court is based on 42 U.S.C. § 1395oo(f) (1) (1982), and our review is governed by the principles of the Administrative Procedure Act, 5 U.S.C. § 706 (1982). For the reasons stated below, we affirm, and adopt the reasoning and opinion of the district court. 576 F. Supp. 1081 (E.D. Pa. 1983).[1]

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* Honorable Mitchell H. Cohen, United States District Judge for the District of New Jersey, sitting by designation.

[1] Although it appears that we are the first court of appeals to address this issue, we note that the District of Columbia Court of Appeals has recently remanded for procedural rea-

I.

2. When promulgated in 1979, the Malpractice Rule completely altered the method by which health-care providers were reimbursed for malpractice insurance premiums associated with the care of Medicare patients. Prior to 1979, malpractice insurance costs were lumped together with all general and administrative costs, and the amount of reimbursement for general and administrative costs was calculated by multiplying the total costs by the percentage utilization rate of Medicare patients. App. at 76-77. Thus, if Medicare patients utilized fifty percent of a health-care provider's beds, the federal government would reimburse the health-care provider for fifty percent of its total general and administrative costs, including malpractice insurance costs.

3. Under the new Malpractice Rule, reimbursement for malpractice insurance costs is not tied to utilization rates, nor are such costs included in the category of general and administrative costs. Rather, reimbursement of malpractice insurance costs is based on the health-care provider's past claims history with Medicare patients, or, if no history exists, on the national ratio of malpractice awards paid to Medicare beneficiaries to malpractice awards paid to all patients. 42 C.F.R. § 405.452(a)(1)(ii) (1983).

4. The district court below found this new regulation to be invalid on three grounds: (1) because the Malpractice Rule was promulgated in violation of the notice and comment procedures of 5 U.S.C. § 553 (1982); (2) because the rule is arbirtary, capri-

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sons a case involving this same issue. *Walter O. Boswell Memorial Hospital v. Heckler*, 573 F. Supp. 884 (D.D.C.), *remanded*, No. 83-2223 (D.C. Cir. Nov. 30, 1984).

cious, and an abuse of the Secretary of Health and Human Services' discretion, and is thus substantively invalid under 5 U.S.C. § 706(2)(A) (1982); and (3) because the rule is in conflict with section 1395(x)(v)(1)(a) of the Medicare Act. We find the reasoning and holding of the district court to be persuasive, and thus adopt the opinion below. We will, however, address the arguments of the parties and amici as to the appropriate remedy in this case.

II.

5. The district court's order provides that "[p]laintiffs' appeals are remanded to the Provider Reimbursement Review Board for such further proceedings as may be required by and appropriate under 42 U.S.C. § 1395oo." App. at 32. The Secretary contends that the appropriate remedy is to remand to her for further rule-making procedures, because any other remedy would unlawfully deprive the Secretary of her exclusive authority to choose reimbursement methods. Appellants' Reply Brief at 20-21 n.13. We find the Secretary's arguments unpersuasive.

6. First, and contrary to the Secretary's contention, the district court did not find that the prior method of reimbursement was invalid.[2] Thus, until rendered invalid by a court decision or replaced by a valid new regulation, the prior method of reimbursement remains operative. *See, e.g., Action on Smoking and Health v. CAB*, 713 F.2d 795, 797 (D.C. Cir. 1983) (recognizing that vacating or rescinding invalidly promulgated regulations has the effect of

[2] Instead, the court merely noted that *the Secretary* believed that the prior regulation was invalid because the utilization approach forced the Medicare program to pay a disproportionate amount of malpractice costs. App. at 38.

reinstating prior regulations). Indeed, because the Malpractice Rule was promulgated as an exception to the general rule of utilization-approach reimbursement, invalidating the exception leaves only the general rule. This result is also consistent with our statutory authority under the Administrative Procedure Act, which envisions the vacation of unlawfully promulgated regulations, 5 U.S.C. § 706(2) (1982). ("The reviewing court shall . . . hold unlawful and *set aside* agency action . . . .") (emphasis added). Our decision today, therefore, has the effect of reinstituting the utilization approach to malpractice insurance cost reimbursement unless and until the Secretary promulgates a valid alternative regulation. *See, e.g., Northwest Hospital, Inc. v. Hospital Service Corp.*, 687 F.2d 985 (7th Cir. 1982) (allowing hospital reimbursement under general rule after invalidating exception).[3]

7. The specific relief in this case, however, is limited to the individual claims of appellees for reimbursement that were considered by the Provider Reimbursement Review Board. Section 405(h) of the Social Security Act, 42 U.S.C. § 405(h) (1982), as incorporated into the Medicare Act by 42 U.S.C. § 1395ii (1982), removes from the federal courts any jurisdiction over claims arising under the Medicare Act for reimbursement, except to the extent allowed in 42 U.S.C. § 1395oo(f) (1982). *See, e.g., National*

[3] The delay already present in this case also informs our decision not to remand for further rulemaking. Plaintiffs seek reimbursement for the 1979-80 fiscal year, and have already waited almost five years for a final determination. It would be inequitable to allow the Secretary to delay further, by second chance rulemaking, reimbursement payments owed to the hospitals and health-care providers.

Association of Home Health Agencies v. Schweiker, 690 F.2d 932, 936-38 (D.C. Cir. 1982), *cert. denied*, 459 U.S. 1205 (1983); *Hadley Memorial Hospital, Inc. v. Schweiker*, 689 F.2d 905 (10th Cir. 1982). Section 1395oo of the Act establishes the Provider Reimbursement Review Board as the forum of first resort, and requires exhaustion of one's remedies there before court review is appropriate, 42 U.S.C. § 1395oo (1982). In this case, those exhaustion requirements were met only for the fiscal year ending June 30, 1980. App. at 9. Thus, the specific relief of our decision is limited to remanding to the Provider Reimbursement Review Board, with the instruction that appellees be awarded reimbursement in accordance with our decision, for malpractice insurance costs incurred during the fiscal year ending June 30, 1980. The judgment of the district court will be affirmed.

APPENDIX B

UNITED STATES DISTRICT COURT
E.D., PENNSYLVANIA

Civ. A. Nos. 82-2856, 82-3465 and 82-3640

ABINGTON MEMORIAL HOSPITAL, ET AL., PLAINTIFFS

v.

MARGARET M. HECKLER, ET AL., DEFENDANTS

MEMORIAL OSTEOPATHIC HOSPITAL, ET AL.,
PLAINTIFFS

v.

MARGARET M. HECKLER, ET AL., DEFENDANTS

ALLEGHENY GENERAL HOSPITAL, ET AL., PLAINTIFF

v.

MARGARET M. HECKLER, ET AL., DEFENDANTS

Dec. 8, 1983

MEMORANDUM AND ORDER

FULLAM, District Judge.

On March 15, 1979, the Secretary of the Department of Health, Education and Welfare—subsequently rechristened the Department of Health and Human Services (HHS)—issued a proposed rule that altered one aspect of the method by which hospitals are reimbursed for their participation in Medicare, the federally funded health insurance program for the aged and disabled. 44 Fed.Reg. 15744. Under Title XVIII of the Social Security Act (the Medicare Act), 42 U.S.C.A. §§ 1395-1395pp (1974 & West Supp. 1983), HHS contracts with health-care providers to render medical services to eligible individuals. Providers are entitled to be reimbursed for all "reasonable costs" of providing such services. *Id.* § 1395f. The "Malpractice Rule," which was promulgated in final form on June 1, 1979, revised the formula for calculating the portion of hospitals' malpractice insurance costs attributable to Medicare patients and thus reimbursable by the Medicare program. 44 Fed.Reg. 31641, codified at 52 C.F.R. § 405.452(b)(1)(ii). The new rule significantly reduces the reimbursement made to most hospitals, and has generated virtually unanimous opposition from the nation's hospitals.

Plaintiffs here are non-profit health-care facilities, including acute-care hospitals, hospital-based skilled nursing facilities, and hospital-based home-health agencies. Plaintiffs challenge the rule on three separate grounds: (1) that the Secretary failed to comply with the notice and comment requirements of the Administrative Procedure Act (APA), 5 U.S.C. § 553, which governs informal rulemaking; (2) that the Malpractice Rule is arbitrary and capricious and thus violates § 706(2)(A) of the APA; and (3) that the

rule is substantively invalid under the Medicare Act because it fails to reimburse hospitals for reasonable costs incurred in providing services to Medicare patients.

I.

Until the Malpractice Rule went into effect in July 1979, malpractice insurance costs—which may take the form of premiums paid to an insurer or payments to a self-insurance fund—were included in the "General and Administrative" category (G & A) of hospital expenses, along with other insurance costs, administrative salaries, and so forth. To apportion G & A costs between Medicare and non-Medicare patients, the G & A total was simply multiplied by the hospital's Medicare utilization rate (*i.e.*, the percentage of patient bed-days used by Medicare patients).

The March 15 Notice of Proposed Rulemaking (NPRM) stated that under the utilization approach the Medicare program paid a disproportionate amount of malpractice costs. 44 Fed.Reg. 15744, 15745 (1979). In support of this conclusion, the Secretary cited a consultant's study, which was interpreted as demonstrating that malpractice awards to Medicare patients were significantly lower than those to other patients, because Medicare patients—being by definition over 65 or disabled—have shorter life expectancies and lower projected future earnings than do other patient populations.

As acknowledged in the preamble to the final rule, public comment was both extensive and unanimously negative, but the final rule was substantially similar to the proposal. As adopted, the Malpractice Rule reimburses a hospital for that percentage of its malpractice insurance costs equal to the dollar ratio of

malpractice losses it has paid to Medicare beneficiaries to total malpractice losses paid to all patients during the current and four preceding fiscal years. Thus, if a hopsital's insurer has paid $100,000 to Medicare claimants and $200,000 to non-Medicare claimants during that five-year period, the hospital would be reimbursed for one-third of its malpractice insurance costs for the current year. The one element that differed from the proposed rule to the final rule concerned hospitals that have paid no malpractice insurance claims during the past five years. Under the proposed rule, such hospitals were to obtain from an independent actuary an estimate of Medicare's share of current malpractice costs. 44 Fed.Reg. at 15745. The final rule eliminates the requirement of an actuarial estimate and replaces it wih a "national ratio" of 5.1%. Thus, hospitals lacking claims-paid experience from the preceding five years will be reimbursed for 5.1% of their insurance costs for the year. The 5.1% figure was derived from data in the consultant's report.

Plaintiffs first challenged the Malpractice Rule during their annual Medicare reimbursement proceedings in 1980. During such proceedings, fiscal intermediaries,[1] who serve under contract as agents of HHS, review Medicare reimbursements that have been made periodically through the year and adjust for over- or under-payment. Thereafter, plaintiffs requested a hearing with the Provider Reimbursement Review Board (PRRB) an entity established by the Medicare Act, 42 U.S.C. § 1395oo, to hear appeals from intermediaries' reimbursement determinations. *Hospital Association of Pennsylvania Group*

[1] Fiscal intermediaries for plaintiffs include Aetna Insurance Company and several regional chapters of Blue Cross.

Appeal, PRRB Case No. 81-332-G. The appeal disputed the legality of the Malpractice Rule as applied for the year ending June 30, 1980. On its own motion, the Board found that it lacked authority to decide the validity of the Malpractice Rule, because it is bound under 42 C.F.R. § 405.186 by existing Medicare regulations. The Board accordingly directed expedited judicial review, pursuant to 42 U.S.C. § 1395oo(f)(1). This action was promptly filed in the Eastern, Middle and Western Districts of Pennsylvania; all three cases were transferred to and consolidated in this court.

II.

Plaintiffs first contend that the rulemaking process followed by the Secretary in adopting the Malpractice Rule failed to conform with the Administrative Procedure Act's notice and comment requirements, which apply to informal rulemaking. 5 U.S.C. § 553. Specifically, plaintiffs allege that the notice of proposed rulemaking failed to provide sufficient information to allow for meaningful comment, and that the basis and purpose statement of the final rule was inadequate.

The general test of the adequacy of a Notice of Proposed Rulemaking (NPRM) is whether it "fairly apprise[d] interested parties of all significant subjects and issues involved," allowing the public to "effectively participate in the ruemaking process." *American Iron and Steel Institute v. EPA*, 568 F.2d 284, 291 (3d Cir. 1977) (citations omitted). Plaintiffs complain that their participation was seriously hampered because the notice failed to describe the methodology or findings of the study that was the sole empirical basis for the Malpractice Rule. In fact,

the NPRM referred only to "a study conducted by an HEW consultant," though the final rule identified the report's author as Westat, Inc. As the D.C. Circuit has recently noted, it is especially important for "[a]n agency to identify and make available technical studies and data that it has employed in reaching the decision to propose particular rules." *Connecticut Light and Power Co. v. Nuclear Regulatory Commission*, 673 F.2d 525, 531 (D.C.Cir.), *cert. denied*, —— U.S. ——, 103 S.Ct. 79, 74 L.Ed.2d 76 (1982).

While the NPRM here challenged is hardly an exemplar by this standard, that defect is not fatal because at least some of the plaintiffs received the consultant's report in time to review it before submitting their comment. *See, e.g.*, comments of the American Hospital Association, Administrative Record Vol. 5, Tab A; the Hospital Corporation of America, Vol. 5, Tab H; the Federation of American Hospitals, Vol. 6, Tab F. Because these organizations represent 6400, 120, and 1,000 hospitals respectively, *id.*, it is not inappropriate to conclude that most interested parties had actual notice, which should be allowed to cure technical defects in notice. *Common Carrier Conference v. U.S.*, 534 F.2d 981 (D.C. Cir. 1976), *cert. denied*, 429 U.S. 921, 97 S.Ct. 317, 50 L.Ed.2d 288. Particularly telling with regard to this case are the comments of the Hospital Association of Pennsylvania, which offered its views "[a]fter a thorough review of the HEW/Westat Study." Vol. 6, Tab H, at 2. Since the Association represents 330 institutions throughout Pennsylvania, plaintiffs here have little cause to complain they lacked effective notice.

Plaintiffs also argue that notice was inadequate because it failed to address the one element contained

in the final rule that was not present in the proposal, namely, the "national ratio". This is a contention which can be disposed of easily. As the Third Circuit has stated, "the submission of a proposed rule for comment does not of necessity bind an agency to undertake a new round of notice and comment before it adopts a rule which is different—even substantially different—from the proposed rule." *American Iron and Steel, supra*, 568 F.2d at 293. The test of adequacy remains whether interested parties were fairiy apprised of the issues before the agency. *Id.* Because the NPRM explicity stated that the rule would cover providers who had not paid any malpractice claims during the past five years, plaintiffs were clearly on notice that the issue was under consideration.

Plaintiffs fare better in attacking the Secretary's basis and purpose statement, which they allege fails to respond adequately to public comments on the proposed rule. As the D.C. Circuit has observed, "the opportunity to comment is meaningless unless the agency responds to significant points raised by the public." *Home Box Office v. FCC*, 567 F.2d 9, 35, *cert. denied*, 434 U.S. 829, 98 S.Ct. 111, 54 L.Ed.2d 89 (1977). Although the Secretary need not address all issues raised by commenters, the response must be specific enough to allow the reviewing court "to see what major issues of policy were ventilated by the informal [rulemaking] proceedings and why the agency reacted to them as it did." *National Industrial Sand Association v. Marshall*, 601 F.2d 689, 716-17 3d Cir. 1979). Furthermore, "an agency decision may not be reasoned if the agency ignores vital comments regarding relevant factors, rather than providing an adequate rebuttal." *Western Coal Traffic League v. U.S.*, 677 F.2d 915, 927 (D.C. Cir.

1982), *cert. denied*, —— U.S. ——, 103 S.Ct. 568, 74 L.Ed.2d 931 (1983). It would have been a miracle of bureaucratic succinctness had the Secretary managed to reply adequately in two scant columns of Federal Register prose to the 600-plus comments that occupy five thick volumes of the administrative record. Unfortunately, no such miracle has been witnessed by this court, which instead finds the Secretary's response woefully inadequate.

Particularly disturbing is the complete lack of response to comments that challenged the statistical validity of the Westat Report, the sole empirical study on which the Malpractice Rule was based. Several commenters questioned the adequacy of the data base. For example, the American Hospital Association noted that providers who self-insure were excluded from the study even though self-insurers constitued 20% of all community hospitals in 1976 and 53% of community hospitals over 500 beds. Administrative Record, Vol. 5, Tab A, at p. 9. The Hospital Corporation of America argued that because the data were collected from only nine insurance companies—out of the 50 which then offered hospital malpractice coverage—and because only claims closed during a four-month period (July to October 1976) were examined, the study offered a quantitatively inadequate sample from which to extrapolate. Vol. 6, Tab H, at 6. The preamble to the final rule contains not a word acknowledging that any commenter criticized the Westat Report; far less did it make an adequate response to those criticisms.

Nor did the Secretary address other points raised by commenters save in a highly conclusory fashion. For example, the American Hospital Association noted that 30% to 40% of the cost of insurance is attributable to administrative expenses such as risk

management, and that claims handling expenses (such as incident investigations and legal fees) do not necessarily parallel ultimate payments. Vol. 5, Tab A, at 8. The Association cited a study by the Rand Corporation which concluded that "only about 35 cents of every dollar in malpractice premiums is paid to successful claimants." *Id.* at 5-6. In light of these shortcomings, the Secretary's basis and purpose statement cannot be considered adequate.[2]

III.

Plaintiffs also contend that adoption of the Malpractice Rule was arbitrary, capricious, and an abuse of discretion, thus violating § 706(2)(A) of the APA. The Supreme Court recently reiterated the proper role for a court reviewing agency action challenged under that provision: to determine "whether the decision was based on a consideration of the relevant factors and whether there had been a clear error of judgment." *Motor Vehicle Manufacturers Association v. State Farm Mutual Automobile Insurance Co.*, —— U.S. ——, 103 S.Ct. 2856, 2865, 2867, 77 L.Ed. 2d 443 (1983) (citations omitted). Plaintiffs argue that the Secretary has committed such an error by basing the Malpractice Rule on inadequate empirical information. Reliance on faulty data has been held to be a clear error of judgment in analogous circumstances. *See Almay, Inc. v. Califano*, 569 F.2d 674 (D.C.Cir. 1977). In *Almay*, the D.C. Circuit held

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[2] This conclusion makes it unnecessary to reach plaintiffs' argument that the Secretary conducted a "sham" rulemaking that failed to genuinely consider public comments. Absent a more thorough response by the Secretary to comments that were submitted, it is not possible for this court to know whether the Secretary considered those comments or not.

that the Food and Drug Administration had acted arbitrarily in adopting a regulation on the basis of a survey, where the director of the bureau that sponsored and designed the survey had seriously questioned the statistical integrity of the survey results. *Id.* at 682.

Here, the authors of the Westat Report noted that "conclusions must be drawn very cautiously because of the possibility of biased data." Westat Report, Administrative Record, Vol. 3, at 2-2. One source of bias arose because many hospitals self-insure, and claims against self-insurers obviously could not show up in a survey of claims closed by insurance companies. *Id.* More telling is a memorandum to the HEW project officer in charge of the Medical Malpractice Study from senior analysts at Westat, who were authors of several chapters of the Final Report. The memorandum's authors noted that the design of the 1976 study made it

> "virtually impossible to generalize beyond the sample . . . to annual totals or to national totals, to cite the most elementary limitation. Beyond that, there was not assurance that the sample was in any way representative of hospitals[,] of physicians, of injuries, of geographic regions, or claimants."

Record, Vol. 4, Tab 3.[3]

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[3] Plaintiffs submit lengthy affidavits that detail additional flaws in the Westat Report. These are not properly before this court, however. A reviewing court may consider evidence outside the administrative record only for background information or to determine if the agency examined all relevant factors or adequately explained its decision; a court may *not* consider outside evidence in substantively evaluating an agency's course of action. *Asarco, Inc. v. EPA*, 616 F.2d 1153, 1160 (D.C. Cir. 1980.)

Of course, an agency need not await perfect data before taking regulatory action. There are limits, however, to the degree of imperfection that is permissible, which the Secretary has surpassed here.

Plaintiffs further challenge the rule as arbitrary and capricious, on the grounds that it produces "bizarre and unfair reimbursement consequences" and is inconsistent with other Medicare reimbursement practices.[4] Because the issues raised by this contention are virtually identical to those presented by plaintiffs' challenge to the rule under the Medicare Act, these issues are addressed in Part IV.

IV.

Finally, plaintiffs contend that the Malpractice Rule is substantively invalid under the Medicare Act because it fails to reimburse hospitals for insurance costs reasonably incurred in treating Medicare patients.[5] The Act requires that hospitals be reimbursed

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[4] Although a court may not substitute its judgment for that of the agency and must keep in mind that judicial oversight of agency actions is narrow in scope, *State Farm, supra,* 103 S.Ct. at 2866, such oversight plays an especially important role where, as here, an agency's policies are in flux. *Greater Boston Television Corp. v. FCC,* 444 F.2d 841 (D.C. Cir. 1970). While agencies must have latitude to adapt their regulations to changed circumstances, *State Farm, supra,* 103 S.Ct. at 2866, new regulations must be fairly reasoned and considered, *State Marine Int'l v. Peterson* 518 F.2d 1070 (D.C. Cir. 1975), *cert. denied,* 424 U.S. 912, 96 S.Ct. 1108, 47 L.Ed.2d 316 (1976). Review of regulatory amendments should thus proceed under the standards that govern other informal rulemaking.

[5] Plaintiffs also allege that in promulgating the malpractice rule, the Secretary violated the statutory directive to "consider . . . the principles generally applied" by insurance companies. 42 U.S.C. § 1395x(v)(1)(A). In making that argu-

for "reasonable costs or customary charges," whichever is less. 42 U.S.C. § 1395f(b). The parties to this litigation agree that it is the "reasonable costs" standard which is involved here. The Act's definition of reasonable costs is lengthy but leaves the Secretary considerable discretion to adopt regulations specifying methods for determining reasonable cost. *Id.* § 1395x(v)(1)(A). The statute does specify, however, that "the reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." *Id.* Furthermore, the Act requires that reimbursement standards "take into account both direct and indirect costs . . . in order that . . . the necessary costs of efficiently delivering covered services to [Medicare patients] will not be borne by [non-Medicare patients]." *Id.*

The government argues that the Secretary should be accorded substantial deference in establishing the method or methods for determining reasonable costs. Of course, this court cannot overrule the Secretary's interpretation merely because it might have interpreted the term "reasonable cost" in another fashion. *See Batterton v. Francis*, 432 U.S. 416, 425, 97 S.Ct. 2399, 2405, 53 L.Ed.2d 448 (1977). Nonetheless, as the Supreme Court recently noted:

> [W]hile reviewing courts should uphold reasonable and defensible constructions of an agency's enabling Act . . . they must not "rubberstamp . . . administrative decisions that they deem in-

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ment, plaintiffs appear to disregard the distinction between "considering" such principles and being bound by them. Because the malpractice rule is being remanded on several other grounds, however, it is not necessary to deal at length with the merits of this position.

> consistent with a statutory mandate or that frustrate the congressional policy underlying a statute."

Bureau of Alcohol, Tobacco and Firearms v. Federal Labor Relations Authority, —— U.S. —— at ——, 104 S.Ct. 439 at 444, 78 L.Ed.2d 195 (1983) (citations omitted.) *See also Pacific Coast Medical Enterprises v. Harris*, 633 F.2d 123, 131 (9th Cir. 1980) ("Even though the Medicare reimbursement area is complex, and to a great degree left to the Secretary to structure, his interpretations are nonetheless subject to our examination.") *Bethlehem Steel v. EPA*, 651 F.2d 861, 867 (3d Cir.1981).

In determining the validity of the plaintiffs' challenge under the Medicare Act and under § 706 of the APA,[6] we must examine how the rule operates in practice. Under the rule, a hospital is reimbursed for that percentage of its malpractice insurance costs equal to the dollar percentage of malpractice awards it has paid in the past five years to Medicare (as opposed to non-Medicare) patients. Thus, if a hospital had three malpractice claims within that time, one of which, for $100,000, was paid to a Medicare patient, and the remaining claims, for $200,000, involved non-Medicare claimants, the hospital would be reimbursed for one-third of its malpractice premiums for the current reporting period. If all three claims had been paid to Medicare patients, the hospital

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[6] The section of the Medicare Act that establishes the Provider Reimbursement Review Board provides for judicial review of PRRB decisions "pursuant to the applicable provisions under chapter 7 of Title 5." 42 U.S.C.A. § 1395*oo*(f)(1) (West Supp. 1983). Similar review is available where, as here, the PRRB has determined that it is without authority to decide the question presented. *Id.*

would be reimbursed for 100% of its malpractice insurance expenditures; but if all three claims had been paid to non-Medicare patients, then the hospital would receive not one cent in reimbursement. The Malpractice Rule takes no account of the hospital's rate of utilization by Medicare patients, so the figures in the above example would apply regardless of whether 1% or 99% of the hospital's patients were Medicare recipients. If a hospital has paid no malpractice claims at all during the past five years, reimbursement is figured according to the national ratio currently set at 5.1%. Such hospitals would be reimbursed for only 5.1% of their malpractice insurance costs, again without regard to their Medicare utilization levels.

The government argues that the Secretary has acted within permissible discretion in establishing a rule that reimburses hospitals under the Medicare program according to the portion of malpractice loss that Medicare patients have historically created. The superficially appealing logic of this formulation, however, entirely neglects two key facts: first, a hospital's malpractice insurance premiums are not established solely with reference to its paid claims history,[7] and second, malpractice insurance does not function solely to ensure that assets will be available to cover a successful claimant's damages. This latter fact is itself a function both of the nature of insurance and of Pennsylvania law. Under 40 Pa. Cons.Stat.Ann. § 1301.701, all hospitals must carry malpractice insurance. Such insurance is thus a nec-

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[7] Instead, "the total cost of protection is a direct function of the provider's annual bed occupancy and outpatient utilization." Comment on behalf of the Chicago Hospital Risk Pooling Program, Administrative Record, Vol. 5, Tab C.

essary, though indirect, cost of providing health care to Medicare patients, because a Pennsylvania hospital cannot provide any services absent such insurance.

Furthermore, malpractice insurance protects an insured's assets against losses that could otherwise threaten its financial stability.[8] Continuity of service benefits all patients, Medicare and other. To the extent that malpractice service costs represent the cost of protecting hospital assets, they are "reimbursable to the extent that this indirect cost benefitted [M]edicare patients." *Presbyterian Hospital v. Harris*, 638 F.2d 1381, 1386 (5th Cir.), *cert. denied*, 454 U.S. 940, 102 S.Ct. 476, 70 L.Ed.2d 248 (1981). Clearly, the extent of benefits to Medicare patients is not simply a function of how many Medicare versus non-Medicare claims a hospital has paid during the past five years, and the Malpractice Rule consequently fails to reimburse actual costs incurred by hospitals.

The statute plainly requires that indirect costs be allocated so as to ensure that non-Medicare patients do not bear costs attributable to Medicare patients, and vice-versa. Since we are dealing with indirect costs, there is in any such allocation, almost by definition, an element of uncertainty. Reasonable estimates and extrapolations are certainly permissible; mathematical precision is not to be expected. But this does not mean that the Secretary is free to choose an allocation formula which is least likely to reflect reality —indeed, as in this case, a formula which seemingly

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[8] This purpose is recognized in the Medicare Provider Reimbursement Manual, published by HHS, which states that a provider must maintain "an adequate insurance program to protect itself against likely losses, particularly losses so great that the provider's financial stability would be threatened." (HIM-15) CCH Medicare & Medicaid Guide ¶ 5999X (emphasis added).

guarantees that the statutory mandate will inevitably be violated in most cases.

It bears repeating that the following facts are, on this record, undisputed: (1) the ratio between malpractice claims paid on account of Medicare patients and malpractice claims paid on account of non-Medicare patients over the most recent five-year period has very little, if any, relationship to the hospital's current cost of maintaining malpractice protection. (2) The "national average" (currently estimated at 5.1%) of that ratio has even less bearing on the current malpractice coverage costs of any particular hospital. (3) The data relied upon in the Westat Report, including the data which produced the 5.1% figure, included both payments made to satisfy the liability of hospitals and claims paid to satisfy the liability of physicians. There is no evidence to support the conclusion that these combined payments provide reliable information about the malpractice payment experience of hospitals. Indeed, there is reason to believe that they do not: It would seem that Medicare patients stand a greater chance of being injured through the negligence of non-physician personnel than younger patients. (4) A very substantial portion—certainly in excess of 50% —of malpractice coverage expense is attributable to claim-handling, litigation, and other expenses unrelated to the amounts paid to claimants. Since the Westat data say nothing about the numbers of claims handled in each category, or the expenses attributable thereto, and since they include only payments in excess of applicable deductibles, even these limited data are open to serious challenge, not addressed in the administrative record.

It is not appropriate for this Court to attempt to specify what method of apportioning malpractice in-

surance costs should be adopted, notwithstanding plaintiffs' implicit argument to the contrary. And I certainly do not mean to suggest that the Secretary's perception that the exposure to malpractice insurance claims and costs attributable to non-Medicare patients is greater than that attributable to Medicare patients is necessarily invalid, or cannot be reflected in the allocation formula adopted. But, while the previous utilization rate method of allocation is not the only possible method, it seems self-evident that any method of allocation which totally ignores utilization rates fails to meet the requirements of the statute.

For the reasons discussed above, I have concluded that the Secretary violated the notice and comment provisions of the APA in adopting the malpractice rule, and that the rule itself is arbitrary and capricious, and fails to conform to the substantive provisions of the Medicare Act. I recognize that these conclusions run counter to other reported decisions on these questions. To date, four other courts have upheld the position of the Secretary. *Athens Community Hospital v. Heckler*, 565 F.Supp. 695 (E.D. Tenn. 1983); *Cumberland Medical Center v. Heckler*, 578 F.Supp. 39 (M.D.Tenn. 1983); *Humana of Aurora, Inc. v. Heckler*, No. 83-7-70 (D.Colo. Sept. 19, 1983); and *Walter O. Boswell Memorial Hospital v. Heckler*, 573 F.Supp. 884 (D.C.C. 1983). After careful consideration, I find myself unable to agree with those decisions.

The *Cumberland* and *Humana* courts merely followed the lead of the *Athens Community Hospital* court, without discussion. And the opinion of the *Athens* court reflects a rather limited analysis of the issues, as is evidenced by the fact that the administrative record appears not to have been part of the

docket before the *Athens* court (see docket sheet, Appendix A to affidavit of H. Buckley Cole, Exhibit C of plaintiffs' memorandum in response to defendants' reply memorandum). I find it difficult to square this approach with the "searching and careful" review mandated by *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416, 91 S.Ct. 814, 823, 28 L.Ed.2d 136 (1971). Moreover, the *Athens* court did not address the anomalous results that the rule produces in practice.

A more complete exploration of the issues involved here is contained in the opinion of my esteemed colleague, Judge Bryant, in the *Boswell* case. Judge Bryant obviously was troubled by the "cloudy" aspects of the administrative record, and found the issue of substantive compliance with the Medicare Act the "thorniest" problem in the case, but the opinion reflects his ultimate conclusion that, in the long run, the imbalances created by the rule would probably balance out in the case of any particular hospital. If there is a distinction between *Boswell* and the present case, it lies in the fact that the Boswell plaintiff had a high percentage of Medicare patients and might therefore actually benefit from the new rule, in the long run. In the present case, I am not at liberty to indulge such an assumption. Be that as it may, with all due deference to the contrary opinions of other judges, I remain unpersuaded that the rule is valid.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 84-1079

ABINGTON MEMORIAL HOSPITAL, ET AL.

v.

HECKLER, MARGARET M., Secretary of the Department of Health and Human Services and DAVIS, CAROLYN K., Administrator Health Care Financing Administration

MEMORIAL OSTEOPATHIC HOSPITAL, ET AL.

v.

HECKLER, MARGARET M., Secretary of the Department of Health and Human Services and DAVIS, CAROLYN K., Administrator Health Care Financing Administration

ALLEGHENY GENERAL HOSPITAL, ET AL.

v.

HECKLER, MARGARET M., Secretary of the Department of Health and Human Services and DAVIS, CAROLYN K., Administrator Health Care Financing Administration

MARGARET M. HECKLER, ET AL., APPELLANTS

Appeal from the United States District Court
for the Eastern District of Pennsylvania

D.C. Nos. 82-2856, 82-3465, 82-3640

Present: HUNTER and WEIS, *Circuit Judges*, and
COHEN, *District Judge* *

JUDGMENT

This cause came on to be heard on the record from the United States District Court for the Eastern District of Pennsylvania and was argued by counsel November 29, 1984.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court, entered December 13, 1983, as amended by order entered January 16, 1984, be, and the same is hereby affirmed in accordance with the opinion of this Court. Costs taxed against appellants.

ATTEST:

/s/ Sally Mrvos
Clerk

December 13, 1984

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* Honorable Mitchell H. Cohen, United States District Judge for the District of New Jersey, sitting by designation.

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 84-1079

ABINGTON MEMORIAL HOSPITAL, ET AL.

vs.

HECKLER, MARGARET M., Secretary of the Department of Health and Human Services and DAVIS, CAROLYNE K., Administrator Health Care Financing Administration

(D.C. Civil 82-2856)

MEMORIAL OSTEOPATHIC HOSPITAL, ET AL.

vs.

HECKLER, MARGARET M., SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

and

DAVIS, CAROLYNE K., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

(D.C. Civil 82-3465)

ALLEGHENY GENERAL HOSPITAL, ET AL.

vs.

HECKLER, MARGARET M., SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

and

DAVIS, CAROLYNE K., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

(D.C. Civil 82-3640)

MARGARET M. HECKLER, ET AL., APPELLANTS

SUR PETITION FOR REHEARING

Present: ALDISERT, *Chief Judge*, SEITZ, GIBBONS, HUNTER, WEIS, GARTH, HIGGINBOTHAM, and BECKER, *Circuit Judges*

The petition for rehearing filed by

APPELLANTS

in the above entitled case having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court in banc, the petition for rehearing is denied.

By the Court,

/s/ James Hunter III
Judge

Dated: February 14, 1985

APPENDIX E

44 Fed. Reg. 31641 (1979)

DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE

Health Care Financing Administration

42 CFR Part 405

Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians; Direct Apportionment of Malpractice Costs to Medicare

AGENCY: Health Care Financing Administration (HCFA), HEW.

ACTION: Final rule.

SUMMARY: This amendment requires malpractice costs incurred by a provider to be directly apportioned to Medicare based on Medicare malpractice loss experience, instead of the current apportionment basis of Medicare's overall utilization of provider services. It requires a separate accumulation and direct apportionment of malpractice insurance premiums and self-insurance fund contributions. In addition, when a provider pays allowable uninsured malpractice losses incurred by Medicare beneficiaries, as a result of the application of deductible or coinsurance provisions of a purchased insurance policy, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, Medicare will reimburse the costs of these losses and any related direct costs. The purpose is to reimburse Medicare providers on a basis more closely related to actual malpractice experience.

DATE: Effective July 1, 1979.

FOR FURTHER INFORMATION CONTACT: Mr. Hugh McConville, (301) 594-9682.

SUPPLEMENTARY INFORMATION:

Background

Under sections 1814(b) and 1833(a)(2)(A) of the Social Security Act, providers of services are to be paid the lesser of reasonable cost of services furnished to beneficiaries or the customary charges made by the provider for the same services. Section 1861(v)(1)(A) of the Act defines reasonable cost and authorizes the Secretary to issue regulations establishing the methods to be used and items to be included in determining reasonable costs. These regulations are set forth in 42 CFR Part 405, Subpart D.

Under current regulations and other instructions issued by Medicare, malpractice costs are accumulated in the administrative and general cost center and allocated to the revenue-producing and other cost centers on the statistical basis of accumulated costs. The costs in the revenue-producing cost centers, including appropriate allocated overhead costs, are then apportioned to Medicare using the ratio of Medicare charges to total charges, or another appropriate statistical basis for ancillary and outpatient services, and the average cost per diem for Medicare beneficiaries for general routine and special care unit services.

This method results in Medicare paying a disproportionate amount of malpractice costs. A national study conducted by a DHEW consultant indicates that malpractice awards for Medicare patients are

significantly lower in amount than losses for other patient population. The lower awards for Medicare patients result because the income potential and life expectancy of these patients are less than the non-Medicare population. Thus, the use of overall Medicare utilization to allocate malpractice costs results in Medicare's paying a disproportionate amount of malpractice costs.

This amendment avoids these disproportionate payments by restructuring the cost finding and cost apportionment procedure. Costs of malpractice insurance premiums and self-insurance fund contributions will be accumulated in a specific malpractice cost center and directly apportioned to Medicare based on the provider's Medicare malpractice loss experience. The dollar ratio of malpractice losses paid for Medicare beneficiaries to total malpractice losses paid for all patients for the current cost reporting period and the preceding 4-year period will provide the basis for apportioning these malpractice costs to Medicare.

The use of an actuarial estimate when a provider has minimal malpractice losses during the 5-year period, as proposed in the Notice of Proposed Rulemaking, could also have resulted in Medicare sharing disproportionately in malpractice costs. Therefore, the final regulation has been revised to require a provider to use the national ratio of the dollar value of Medicare malpractice awards to total malpractice awards as determined by the 1976 Departmental closed claim study performed by Westat, Inc. This national ratio, as determined by the latest study, is 5.1 to 100 or 5.1 percent and is to be used instead of an actuarial estimate for apportioning malpractice insurance premiums or self-insurance fund contributions. When a provider has no malpractice loss ex-

perience for the 5-year period specified in the final regulation, Medicaid reimbursement of malpractice insurance premiums or self-insurance fund contributions would be determined by applying the national ratio of 7.5 to 100 (or 7.5 percent). This ratio was also determined by the most recent Departmental study of closed claims.

If a provider pays allowable uninsured malpractice losses for Medicare beneficiaries, as a result of the application of deductible or coinsurance provisions of a purchased insurance policy or a funded self-insurance program, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, those losses and related direct costs will be directly assigned to Medicare for reimbursement.

This regulation impacts Medicaid reimbursement because under 42 CFR 447.261(b)(2), for payment of inpatient hospital services, States participating in Medicaid must either adopt Medicare standards and principles for determining reasonable cost reimbursement as set forth in 42 CFR 405.402 through 405.455 or must meet the criteria in 42 CFR 447.261(d).

Discussion of Major Comments

A Notice of Proposed Rulemaking for this regulation was published on March 15, 1979, in the Federal Register (44 FR 15641). Comments were received from many members of the health care industry. Responses to the most significant comments are described below.

1. *Opposition to the Direct Apportionment of Malpractice Costs.* All comments received were against the proposal and recommended that we withdraw it entirely. The main argument against the proposal

was that the incurrence of malpractice costs bears no relationship to the financial class of the patient. Therefore, all patients should share equally in malpractice insurance costs or losses because these costs are incurred primarily for the benefit of the total overall patient population and for the protection of facility assets. Other arguments stressed that charges to private patients and third-party payors would necessarily increase in order to recover costs normally reimbursed by Medicare, and that additional costs for recordkeeping would be incurred.

We are aware that insurance companies generally do not determine insurance rates for malpractice insurance based upon the financial status of the patients. However, information about malpractice loss experience by type of patient (i.e., Medicare) is readily available. Moreover, this regulation is not based on a relationship between malpractice losses and the financial status of patients. As explained above, it is grounded on a direct calculation of the costs incurred in furnishing health care to Medicare beneficiaries.

We are also aware that charges to private patients and third-party payors may increase and that additional costs for recordkeeping may be incurred; we believe that this amendment is necessary in order to prevent the program from paying a disproportionate amount of substantial malpractice costs.

2. *Direct Assignment of Overhead Costs.* We received comments urging that overhead costs other than malpractice costs also be directly apportioned. We believe that the current cost finding and apportionment procedure is generally an equitable method of allocating other overhead costs. However, because malpractice costs are so significant and the dispro-

portionate allocation of malpractice costs to Medicare is so great, we believe a unique exception is warranted to deal with these costs.

3. *Cash Flow.* We received comments concerning the possibility of the apportionment ratio adversely affecting provider cash flow. If a provider pays a large dollar amount of Medicare malpractice claims in the current year and has little or no prior Medicare malpractice claim experience for the preceding 4-year period, the apportionment ratio of Medicare malpractice claim loss experience to total malpractice claim loss experience for the current period necessarily becomes smaller due to the averaging of the malpractice loss experience ratios for the entire 5-year period. Over the succeeding 5-year period, reimbursement would eventually reflect Medicare's malpractice claim experience. However, for the current year, the apportionment ratio (5-year average) would apportion to Medicare an amount less than what would have been apportioned had the current year's ratio for malpractice claim loss experience been used, thereby lowering Medicare reimbursement. Providers, therefore, would have to use their own funds until such time as Medicare reimbursement "catches up."

We wish to study this issue further, especially when circumstances are reversed and Medicare payment is greater than it might otherwise be, due to a particularly large malpractice claim in a given year. One possible solution could be a modification to 42 CFR section 405.454(h), Accelerated payments to providers, to provide relief to providers whose cash flow is adversely affected by the apportionment ratio. If so, a proposed change to this regulation section would be published in the Federal Register for comment.

4. *Claims Management.* We also received comments stating that this regulation would provide an incentive for providers to settle Medicare malpractice claims without providing the same degree of claims management as for non-Medicare malpractice claims of similar nature. We do not believe that providers would actually settle Medicare malpractice claims in such a manner. Furthermore, we do not believe that others involved in such matters, such as legal firms, insurance companies, and insurers would allow these practices. However, we will watch this carefully and take action if necessary.

EFFECTIVE DATE: This amendment to the Medicare reimbursement regulations is effective for cost reporting periods beginning on or after July 1, 1979. Instructions will be provided through fiscal intermediaries for the treatment of malpractice costs for these periods and cost reporting forms will be supplied before filing.

42 CFR Part 405 is amended as follows:

1. Section 405.452 is amended by revising paragraph (b) (1) to read as follows:

§ 405.452 Determination of cost of services to beneficiaries.

* * * * *

(b) *Principle for cost reporting periods starting after December 31, 1971.* Total allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. For cost reporting periods starting after December 31, 1971, the methods of apportionment are defined as follows:

(1) *Departmental Method.* (i) Except as provided in paragraph (b)(1)(ii) of this section with respect to the direct apportionment of malpractice costs, the ratio of beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department; to this is added the cost of routine services for program, beneficiaries, determined on the basis of a separate average cost per diem for general routine patient care areas, taking into account, to the extent pertinent, an inpatient routine nursing salary cost differential (see § 405.430 for definition and application of this differential), and in hospitals, a separate average cost per diem for each intensive care unit, coronary care unit, and other special care inpatient hospital units.

(ii) *Exception:* For cost reporting periods beginning on or after July 1, 1979, costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned to Medicare. The apportionment must be based on the dollar ratio of the provider's Medicare paid malpractice losses to its total paid malpractice losses for the current cost reporting period and the preceding 4-year period. If a provider has no malpractice loss experience for the 5-year period, the costs of malpractice insurance premiums or self-insurance fund contributions must be apportioned to Medicare based on the national ratio of malpractice awards paid to Medicare beneficiaries to malpractice awards paid to all patients. The Health Care Financing Administration will calculate this ratio periodically based on the most recent departmental closed claim study.

If a provider pays allowable uninsured malpractice losses incurred by Medicare beneficiaries, either

through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, such losses and related direct costs must be directly assigned to Medicare for reimbursement.

(Sections 1102, 1814(b), 1881(v)(1) of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395x(v), 1395hh).)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance; No. 13,774. Medicare—Supplementary Medical Insurance.)

Dated: May 23, 1979.

Leonard D. Shaeffer,
Administrator, Health Care Financing Administration.

Approved: May 24, 1979

Joseph A. Califano, Jr.
Secretary.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, *et al.*,
Petitioners,

v.

ABINGTON MEMORIAL HOSPITAL, *et al.*,
Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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August 19, 1985

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COUNTER STATEMENT OF QUESTION PRESENTED

Should this Court deny certiorari, where the Third Circuit Court of Appeals in reviewing the malpractice rule, which established a unique exception to the method of calculating Medicare reimbursement for the cost of malpractice insurance, properly determined that

(1) the rule was invalid because the Secretary of the Department of Health and Human Services:

(a) failed to comply with the notice and comment requirements of the Administrative Procedure Act ("APA") 5 U.S.C. § 553;

(b) promulgated a rule which is arbitrary, capricious and an abuse of her discretion and substantively invalid under the APA, 5 U.S.C. § 706(2)(A);

(c) promulgated a rule which is substantively invalid under the Medicare Act because it failed to reimburse hospitals for reasonable costs actually incurred in providing services to Medicare patients; and that

(2) respondents should be reimbursed for the 1979-80 cost reporting year under the traditional utilization reimbursement method?

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IN THE

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v.

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Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

COUNTERSTATEMENT OF THE CASE

This Honorable Court should deny the petition for a writ of certiorari because every court of appeals ruling on the issue [1] has determined that the Secretary's regulation is not valid and that Medicare providers should be reimbursed for their services under the prior utilization method for fiscal year 1979-80 without remand to the Secretary for further rulemaking.

This case began when respondents, non-profit health care facilities [2] participating in the Medicare Program, challenged the procedural and substantive validity of a hastily promulgated regulation (malpractice rule) that drastically changed the reimbursement method for the costs of medical mal-

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[1] *See* discussion, Section I below.

[2] Respondents, plaintiffs below, are all non-profit health care facilities, including acute care hospitals, hospital-based skilled nursing facilities, and hospital-based home health agencies, located in the Commonwealth of Pennsylvania and participating in the Medicare program.

practice insurance for Medicare patients, 42 C.F.R. § 405.452(b)(1)(ii). Medicare is a health insurance program for the aged and disabled which was enacted in 1965 under Title XVIII of the Social Security Act, 42 U.S.C. § 1395, *et seq.* (the "Medicare Act").

A. The Medicare Act

Under the Medicare Act each provider participating in the Medicare program is entitled to reimbursement for the "reasonable costs" of the services furnished to Medicare patients. 42 U.S.C. § 1395(f)(b). The Medicare Act defines "reasonable costs" as the "costs actually incurred" excluding costs which are unnecessary to the efficient delivery of needed health services. It requires the Secretary to reimburse "both direct and indirect costs." 42 U.S.C. § 1395x(v)(1)(A). The Secretary must promulgate regulations to ensure that the ". . . necessary costs of efficiently delivering covered services to individuals covered by [Medicare] . . . will not be borne by individuals not so covered. . . ." *Id.*

Historically, Medicare paid health care providers for services to Medicare patients by reimbursement of costs in providing the services. Significantly, in 1983 Congress amended the Medicare Act and replaced the reimbursement scheme with a prospective payment system which pays a fixed amount per patient depending upon the diagnosis. 42 U.S.C. § 1395ww. Thus, beginning on or after October 1, 1983, most hospitals have been paid for Medicare services under the prospective payment system.[3]

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[3] The law provides for a three year phase in period. Thus, after October 1, 1986 most hospitals will be reimbursed entirely under the prospective payment system and not on a reasonable cost basis. This legislation does not apply to the present action, which is for reimbursement under the prior law for the fiscal year ending June 30, 1980. However, the prospective payment legislation demonstrates that the issue presented to this Court is not one of future importance. Thus, as the Court recognized in *Walter O. Boswell Memorial Hospital v. Heckler*, 749 F.2d 788, 791 n.3 (D.C. Cir. 1984): "Events have since largely overtaken the Malpractice Rule."

B. The Utilization Method

Since its inception, Medicare applied a utilization approach to determine the proportion of a provider's total costs to be reimbursed by the program. For example, if Medicare patients used 30% of the services of an operating room of a hospital, Medicare reimbursed 30% of the hospital's allowable reasonable costs associated with the operating room.

Before the malpractice rule, costs associated with malpractice insurance were allocated to Medicare in the same manner as other costs included within the General and Administrative (G and A) cost center. The G and A cost center consistently included all insurance costs, including fire, casualty, workers' compensation and malpractice insurance premiums. Medicare reimbursed these costs in the same manner as all other costs: in proportion to Medicare's utilization of the provider's services. 42 C.F.R. § 405.452(b)(1)(i); Provider Reimbursement Manual, Chap. 22 (HIM-15). (*See,* CCH Medicare & Medicaid Guide, ¶ 6031.) Removing malpractice insurance costs from the G and A cost center, unlawfully destroyed the rationale for pooling all G and A costs and upset the integrity of the entire Medicare cost-finding and apportionment process.

C. The Malpractice Rule

The malpractice rule established what the Secretary labeled a "unique exception" to the traditional Medicare utilization approach. C.A. App. 81-82. The rule singled out malpractice insurance costs from all other costs for special treatment.[4] The rule reimbursed malpractice insurance costs on the basis of the provider's recent paid claims experience or, if a provider had no malpractice paid claims for the previous five

[4] Some of the purported facts in the Secretary's Statement (Pet. 3-11) are undocumented, others are not supported by the references in the Petition, respondents vigorously disagree with most, and the court below rejected many. Without belaboring every point, by way of example, the Secretary cited as the sole basis for the malpractice rule the Medical Malpractice Closed Claim Study ("We[illegible]port"). Pet. 5. All circuit courts have concluded that it is defective and [illegible]t a valid basis for the rule. *See* cases cited in notes 5 and 6 below, including *Boswell, supra.* Thus, many of the purported "facts" in the Petition have been discredited by the lower courts.

years, on the basis of a purported "national ratio" of 5.1% for the cost reporting year at issue. *Id.* All other G and A costs, as well as all other provider costs, were still reimbursed under the traditional utilization approach.

Malpractice premiums are simply not based upon past paid claims. Malpractice insurance premiums reflect many items other than paid claims, such as expected loss costs, expected expenses, and a margin to cover variations in claim costs and investment income. Providers purchase malpractice insurance to protect against all claims whether or not such claims are ultimately paid. Paid claims can vary from year to year from zero to several million dollars. Malpractice insurance is necessary for providers to service all patients. C.A. App. 241-247.

The fundamental premise of the malpractice rule is flawed. Although there is no direct connection between premium costs and past paid claims, that is the sole basis of the regulation. The malpractice rule is premised upon the faulty assumption that apportioning the cost of malpractice insurance on the basis of a provider's past five years' paid claims reimburses the actual cost of insuring Medicare patients for potential future claims. There is absolutely no evidence in the record before the administrative agency to establish that paid claims during the past five years provides a reasonable cost related basis for apportioning the cost of malpractice insurance between Medicare and non-Medicare patients. The overwhelming evidence in the administrative record establishes that past claims paid for either Medicare or non-Medicare patients is not a reasonable method for apportioning the actual cost of insuring Medicare patients.

To illustrate the impact of the malpractice rule and its arbitrary and bizarre results, assume that hospitals X and Y both had premium costs of $100,000, utilization rates of 30% Medicare patients, and one paid claim during the relevant five year period. Hospital X paid its claim to a Medicare patient, while Hospital Y paid its claim to a non-Medicare patient. Under the traditional utilization approach, both hospitals

would receive $30,000 in reimbursement (30% x $100,000). In contrast, under the malpractice rule, Hospital X is reimbursed its entire premium cost of $100,000 even if its paid claim was $25 and even though some of its premium cost is also reimbursed from other third-party payors such as Blue Cross and commercial insurers. Hospital Y is not reimbursed for any of its premium costs. Thus, Hospital Y is totally denied Medicare reimbursement for expenses which are indisputably necessary and proper costs of rendering care to Medicare patients. By way of further contrast, Hospital Z, with malpractice premium costs of $100,000, a 30% utilization rate and no paid claims during the five year period is reimbursed 5.1% of its malpractice premium costs or $5,100, whether its utilization rate is 1% or 99%.

Under the malpractice rule, reimbursement of malpractice costs bears no relationship to premium costs actually incurred with respect to Medicare patients. The rule creates serious inequities among providers and disregards the statutory mandate under the Medicare Act for reimbursement of the reasonable necessary costs actually incurred. 42 U.S.C. § 1395x(v)(1)(A).

D. Proceedings Below

For fiscal year 1979-80, respondents were reimbursed under the malpractice rule rather than on the basis of Medicare utilization. Respondents challenged the malpractice rule by appealing to the Provider Reimbursement Review Board (PRRB). The PRRB found that it lacked authority to decide the validity of the malpractice rule and directed judicial review of the providers' appeal pursuant to 42 U.S.C. § 1395oo(f)(1).

Respondents filed actions in the United States District Courts for the Eastern, Middle and Western Districts of Pennsylvania. These actions were consolidated by consent in the Eastern District.

Upon cross motions for summary judgment, the district court entered judgment in favor of the providers. The court held that the Secretary's basis and purpose statement was "woefully inadequate" in that it failed to adequately respond to

the overwhelming negative public comments on the proposed rule and failed to address the comments pointing out the defects in the Westat Report, the sole basis of the rule. Thus, the Secretary violated the procedural requirements of the APA in promulgating the Rule. Pet. App. 18a.

The district court also found that the malpractice rule was arbitrary and capricious and an abuse of discretion in violation of § 706(2)(A) of the APA because it was based upon faulty, biased data, produced bizarre and unfair reimbursement consequences and was inconsistent with other Medicare reimbursement practices. Pet. App. 19a-20a.

Finally, the district court concluded that the malpractice rule was substantively invalid under the Medicare Act because it failed to reimburse hospitals for costs reasonably incurred in treating Medicare patients. Pet. App. 25a-26a. The district court noted that a hospital's malpractice insurance costs are not established solely with reference to its paid claims history and that they are a necessary though indirect cost of providing health care to Medicare patients and assure continuity of service to the benefit of all patients. *Id.* Therefore, the district court concluded that the malpractice rule was inconsistent with and failed to meet the requirements of the Medicare Act. Pet. App. 27a.

Upon respondents' motion, which the Secretary did not oppose, the district court clarified its order granting summary judgment to require that the matter be remanded to the PRRB for reimbursement rather than to the Secretary for further proceedings. C.A. App. 1 (Doc. No. 51).

The Secretary appealed the district court's decision to the United States Court of Appeals for the Third Circuit. On December 13, 1984, that court affirmed the district court's decision and adopted its well reasoned opinion invalidating the malpractice rule. Pet. App. 1a-10a and 29a-30a. The Third Circuit denied the Secretary's specific request that the matter be referred to her for further rulemaking on the grounds that after invalidating the exception, the general reimbursement rule remained operative and that the providers had already waited

long enough for reimbursement for the 1979-80 fiscal year. The Secretary's petition for rehearing was denied on February 14, 1985. Pet. App. 31a-33a.

The Secretary filed her petition for writ of certiorari on July 14, 1985. Respondents oppose the request that this Court grant certiorari.

REASONS FOR DENYING THE PETITION

There are no special and important reasons for granting certiorari in this case. Since all seven courts of appeals that have ruled on the validity of the malpractice rule have invalidated it, there is no conflict among the circuits and no basis for the Secretary's claim of unevenhanded administration of the Medicare program. Inasmuch as most providers are now being paid for services to Medicare patients primarily on the basis of diagnosis and not on the reasonable cost basis, this case does not present an issue of continuing importance.

I. THERE IS NO CONFLICT AMONG THE CIRCUIT COURTS.

A. All Seven Circuit Courts and Substantially All District Courts Have Invalidated the Malpractice Rule.

The malpractice rule has suffered resounding defeats in all eight circuit court cases without a single dissent.[5] All seven courts of appeals that have ruled on the validity of the

[5] *St. James v. Heckler*, 760 F.2d 1460 (7th Cir. 1985); *Humana of Aurora, Inc. v. Heckler*, 753 F.2d 1579 (10th Cir. 1985); *Lloyd Noland Hospital and Clinic v. Heckler*, 762 F.2d 1561 (11th Cir. 1985); *Abington Memorial Hospital v. Heckler*, 750 F.2d 242 (3rd Cir. 1984); *DeSoto General Hospital v. Heckler*, No. 84-3577 (5th Cir. July 5, 1985); *Menorah Medical Center v. Heckler*, No. 84-2257 (8th Cir. July 24, 1985); *Bedford County Memorial Hospital v. Health and Human Services*, No. 84-1672 (4th Cir. August 14, 1985). Additionally, the District of Columbia Court of Appeals remanded the *Boswell* case to the district court for reconsideration after review of the full rule-making record. *Boswell, supra*, 749 F.2d at 790.

malpractice rule have held it invalid. Moreover, of thirty-two district court decisions, twenty-six invalidated the malpractice rule.[6] All six decisions which upheld the validity of the rule [7] were based upon the *Athens* and *Boswell* district court decisions

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[6] *Mt. Carmel Mercy Hospital v. Heckler,* 581 F.Supp. 1311 (E.D. Mich. 1983); *Chelsea Community Hospital v. Heckler,* Civ. No. 83-6126-AA (E.D.Mich. Dec. 20, 1983); *Albany General Hospital v. Heckler,* 584 F.Supp. 614 (D.Ore. 1984); *St. James Hospital v. Heckler,* 579 F.Supp. 757 (N.D.Ill. 1984), *aff'd,* 760 F.2d 1460 (7th Cir. 1985); *Humana of Illinois, Inc. d/b/a Springfield Community Hospital v. Heckler,* 584 F.Supp. 618 (C.D.Ill. 1984), *aff'd,* Nos. 84-1478, 84-1727 (7th Cir. Apr. 18, 1985); *Bedford County Memorial Hospital v. Heckler,* 583 F.Supp. 367 (W.D.Va. 1984) *aff'd,* No. 84-1672 (4th Cir. August 14, 1985); *Alexandria Hospital v. Heckler,* 586 F.Supp. 581 (E.D.Va. 1984) *aff'd,* No. 84-1672 (4th Cir. August 14, 1985); *Lloyd Noland Hospital and Clinic v. Heckler,* Civ. No. 83-PT-0868-S (N.D.Ala. Apr. 6, 1984), *aff'd,* 762 F.2d 1561 (11th Cir. 1985); *Metropolitan Hospital, Inc. v. Heckler,* Civ. No. C83-502A (N.D.Ga. June 25, 1984), *aff'd,* Nos. 84-7444, 84-8699 (11th Cir. June 12, 1985); *Parkway Medical Center, et al. v. Heckler,* Civ. Nos. 83-1005, 83-1700 (S.D.Fla. Sept. 24, 1984); *DeSoto General Hospital v. Heckler,* Civ. No. 83-1050-B (M.D.La. June 22, 1984), *aff'd,* No. 84-3577 (5th Cir. July 5, 1985); *East Jefferson General Hospital v. Heckler,* Civ. No. 83-4107-C (E.D.La. Oct. 19, 1984); *Menorah Medical Center v. Heckler,* Civ. No. 83-0822-CV-W-4 (W.D.Mo. July 26, 1984) *aff'd,* No. 84-2257 (8th Cir. July 24, 1985); *Mercy Medical Center and Unity Medical Center v. Heckler,* Civ. No. 3-82, 1724 (D.Minn. Aug. 17, 1984); *Sisters of St. Mary, et al. v. Heckler,* Civ. Nos. 83-0789C(4), 83-1604C(C) (E.D.Mo. Nov. 6, 1984); *Arkansas Methodist Hospital, et al. v. Heckler,* Civ. Nos. J-C-83-106, J-C-83-148 (E.D.Ark. Nov. 1, 1984); *St. Anthony Regional Hospital, et al. v. Heckler,* Civ. No. C-84-37 (N.D. Iowa Oct. 12, 1984); *Marshalltown Area Community Hospital v. Heckler,* Civ. No. 84-226-B (S.D.Iowa Dec. 17, 1984); *Bethesda Hospital v. Heckler,* Civ. No. C-1-83-622 (S.D.Ohio Apr. 30, 1985); *St. Joseph's Hospital v. Heckler,* 583 F.Supp. 1545 (D.Ariz. 1984); *Charter Medical Corp. v. Heckler,* 604 F.Supp. 638 (M.D.Ga. 1985); *Abington Memorial Hospital v. Heckler,* 576 F.Supp. 1081 (E.D.Pa. 1983) *aff'd,* 750 F.2d 242 (3rd Cir. 1984); *Tallahassee Memorial Regional Med. Ct. v. Heckler,* No. TCA 83-7128-WS (N.D. Fla. June 21, 1985); *Brentwood Hospital Inc. v. Heckler,* No. 83-0502 (W.D. La. July 3, 1985); *Adair County Health Center Inc. v. Heckler,* Civ. No. 84-771-E (W.D. Okla. July 25, 1985); and *Lifemark Hospitals of Texas, Inc. v. Heckler,* Civ. No. G-83-315 (S.D. Tex. August 13, 1985).

Although the decisions in *Charter Medical Corp., supra, Tallahassee Memorial, supra,* and *Brentwood Hospital supra,* were decided before the petition was filed, they are not mentioned or cited in the petition.

[7] *Athens Community Hospital v. Heckler,* 565 F.Supp 695 (E.D. Tenn. 1983); *Cumberland Medical Center v. Heckler,* 578 F.Supp. 39 (M.D. Tenn. 1983); *Benton County General Hospital v. Heckler,* Civ. No. 82-1289 (W.D.

(footnote continues)

which were decided without the full administrative record and before the *Abington* decision. Moreover, of those six decisions, one has been reversed, one has been vacated and remanded and one is presently before the Eighth Circuit upon the providers' motion for summary reversal on the basis of the contrary circuit court decision in *Menorah Medical Center, supra.*[8]

Indeed, although the petition includes half-hearted arguments on behalf of the malpractice rule, recognizing that it cannot be sustained as promulgated, the Secretary suggests that those issues are not ripe for plenary review. Pet. 15. Thus, the overwhelming case law invalidating the malpractice rule, particularly the unanimity of the circuit court decisions and the Secretary's preference to avoid review, demonstrate that review of this case is not warranted.

B. The Remand of *Boswell* Because of the Inadequate Record Does Not Establish Conflict Among the Circuits.

The Secretary attempts to create a conflict among the circuit courts where none exists. Although the petition refers to dicta of the Court in *Boswell, supra,* Pet. 8, 14-15, the District of Columbia Court in *Boswell* held that the case must be remanded to the district court to consider the full rulemaking record which had not been before it at the time of its decision.[9]

(footnote continued)

Tenn. Oct. 25, 1983); *Humana of Aurora, Inc. d/b/a/ Aurora Community Hospital v. Heckler,* Civ. No. 83-Z-70 (D.Colo. Sept. 25, 1983), *rev'd,* 753 F.2d 1579 (10th Cir. 1985); *Walter O. Boswell Memorial Hospital v. Heckler,* 573 F.Supp. 884 (D.D.C. 1983), *remanded* 749 F.2d 788 (D.C. Cir. 1984); *Normandy Osteopathic-North Hospital v. Heckler,* Civ. No. 83-1687C(1) (E.D. Mo. Dec. 21, 1984), appeal docketed, No. 85-1247 (8th Cir. Feb. 19, 1985) (motion for summary reversal filed Aug. 8, 1985).

[8] *See* note 7 above.

[9] Moreover, the courts have specifically interpreted the *Boswell* decision as a resounding defeat for the Secretary: "The District of Columbia Circuit clearly signalling its view remanded a district court decision upholding the rule." *DeSoto General Hospital, supra,* slip op. at 5. "... the District of Columbia Circuit has strongly suggested that the Secretary has engaged in arbitrary and capricious action in enacting the malpractice rule." *Brentwood Hospital, Inc., supra,* slip op. at 12. *See also Lloyd Noland, supra,* 762 F.2d at 1566-67 and *St. James, supra,* 760 F.2d at 1467, 1471.

The D. C. Circuit did not make any determination of the substantive issues in the case. Thus *Boswell* is not inconsistent with the holding of the Third Circuit or the other six circuits which invalidated the rule.

The Secretary's reliance on dicta in *Boswell* cannot create a conflict between the circuit courts. The virtually unanimous case law invalidating the malpractice rule, demonstrates that review by this Court of the extensively litigated issues would be a needless waste of judicial resources.

II. THE LIMITED RELIEF ORDERED BY THE THIRD CIRCUIT HAS BEEN UNANIMOUSLY APPLIED BY THE OTHER COURTS CONSIDERING THE ISSUE.

The Third Circuit properly remanded providers' appeals to the PRRB for reimbursement of their malpractice costs for fiscal year 1979-80 under the apportionment method:

> Thus, the specific relief of our decision is limited to remanding to the Provider Reimbursement Review Board, with the instruction that appellees be awarded reimbursement in accordance with our decision, for malpractice insurance costs incurred during the fiscal year ending June 30, 1980. Pet. App. 10a.

The Court specifically rejected the Secretary's request to remand for further rulemaking [10] on the grounds that the request was inequitable since the providers had already waited nearly five years (now even a longer time period has elapsed) to be properly reimbursed:

> The delay already present in this case also informs our decision not to remand for further rulemaking. Plaintiffs seek reimbursement for the 1979-80 fiscal year, and have already waited almost five years for a

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[10] The Secretary's support for this suggestion purports to be based on an incomplete reference to the district court decision which actually dealt with a different issue. Pet 11, n. 10. The court actually stated:

> But, while the previous utilization rate method of allocation is not the only possible method, it seems self-evident that any method of allocation which totally ignores utilization rates fails to meet the requirements of the [Medicare] statute. Pet. App. 27a.

> final determination. It would be inequitable to allow the Secretary to delay further, by second chance rule-making, reimbursement payments owed to the hospitals and healthcare providers. (Pet. App. 9a.)

The limited relief granted by the Third Circuit in this case is consistent with the directives of the APA which provide that a court in reviewing agency action is empowered to " . . . compel agency action unlawfully withheld or unreasonably delayed; and . . . hold unlawful and set aside agency action . . . found to be . . . arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law . . . . " 5 U.S.C. § 706(1)(2)(A)(D). As the District of Columbia Court of Appeals stated in *Action on Smoking and Health v. CAB,* 713 F.2d 795 (D.C. Cir. 1983), after invalidating unlawfully promulgated regulations, " . . . the judgment of this Court had the effect of reinstating the rules previously enforced . . . . " *Id.* at 797.

The limited relief awarded by the Third Circuit is also consistent with the Medicare Act. 42 U.S.C. § 1395ff. The Court invalidated the unique exception for malpractice costs to the general apportionment rule and thereby entitled providers to the reimbursement for malpractice premium costs they would have received had the regulation been applied without the exception.

Similarly, after invalidating the malpractice rule, the court in *Lloyd Noland Hospital, supra,* 762 F.2d at 1569 remanded to the PRRB for payment under the utilization method, holding:

> The only proper result is to pay the hospital according to existing regulations. The hospitals seek reimbursement for the fiscal year 1979-80. Four years is long enough for them to wait . . . We remand to the PRRB for payment of the hospital's insurance costs . . . without reference to the malpractice rule. . . . (citations omitted)

After invalidating the malpractice exception other courts even after being advised of the proposed rule have also ordered reimbursement for malpractice premium costs in accordance with the prior utilization rule. *Bedford County Memorial Hospital, supra,* slip op. at 17-18; *Menorah Medical Center,*

supra, slip op. at 10-11; *DeSoto General Hospital, supra,* slip op. at 10; *Marshalltown Area Community Hospital, et al., supra,* (order remanding case); *Charter Medical Corporation, supra.,* 604 F. Supp. at 640; *Mercy Medical Center, supra,* (final order); *Brentwood Hospital, Inc., supra,* slip op. at 16; and *Lifemark Hospital, supra.*

Similarly in *Northwest Hospital, Inc. v. Hospital Service Corp.,* 687 F.2d 985 (7th Cir. 1982) the Seventh Circuit set aside an exception contained in the Medicare regulations. As a result of invalidating the exception the Court held that the provider was entitled to reimbursement for the expense it would have received had the Medicare regulations been applied without the exception. *Id.* at 995-96. The relief granted by the Third Circuit in the present case is precisely that awarded by the Seventh Circuit in *Northwest Hospital, Inc., supra.*[11]

The Secretary has presented no reason to disturb the relief ordered by the Third Circuit in this case. Indeed, the Secretary recognizes that "... this is not the optimal moment for ... plenary consideration" of the relief granted by the Third Circuit. Pet. 11. We agree.

III. VACATING THE DECISION AND REMANDING THE CASE WILL CAUSE MANIFEST INJUSTICE TO RESPONDENTS AND WILL OVERWHELM THE COURTS WITH DUPLICATIVE LITIGATION

To circumvent the tidal wave of decisions invalidating the malpractice rule, the Secretary boldly asks this Court to vacate the judgment below and remand for second chance rule-making. This request flaunts the power of the courts, and the specific relief ordered by the Third Circuit. Any further delay under the circumstances presented would be manifestly unjust to respondents. In addition, the Secretary's request if granted, would open a flood-gate of unnecessary and duplicative litigation.

The Secretary requests that this Court grant the petition, vacate the decision below and remand the case to allow the

[11] For these reasons, the cases cited by the Secretary at Pet. 16 are irrelevant since they concern agency action in entirely different circumstances than presented in this case.

Third Circuit to reconsider its decision because the Secretary proposes to repromulgate the malpractice rule, 50 Fed. Reg. 25,179 (June 17, 1985). The proposed rule is identical[12] to the present malpractice rule invalidated by the lower courts except for a change in the "national ratio". It purports to be retroactive[13] to the 1979-80 cost reporting year, which is involved in this appeal.

The Secretary's request directly contravenes the Third Circuit's decision not to remand for further rulemaking. Indeed, all courts considering the question have explicitly determined not to remand to the Secretary for second chance rulemaking.[14] Because of the timing of the proposed new rule and the fact that the Secretary admits that she intends to repromulgate the same rule it is obvious that the Secretary is not seeking to exercise her statutory authority but rather to preempt the numerous adverse decisions against her. This blatant attempt to evade the decisions of all seven circuit courts and numerous district courts should not be sanctioned by this Court.

A proposed new rule that has not yet been and may never be promulgated cannot afford a basis for this Court to vacate

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[12] Thus, if adopted as proposed, the proposed rule is still invalid based upon the reasoning of the many courts invalidating the present malpractice rule. *See* notes 6 and 7 above.

[13] Contrary to the Secretary's assertion (Pet. 16, n. 13), she is not authorized to engage in retroactive rulemaking. See *Daughters of Miriam Center for the Aged v. Matthews*, 590 F.2d 1250, 1258, n. 23 (3d Cir. 1978). *See also Heckler v. Community Health Services of Crawford County Inc.* ____ U.S. ____, 104 S. Ct. 2218, 2220-2221 (1984). *But see Kingsbrook Medical Center v. Richardson*, 406 F.2d 663 (2d Cir. 1973).

[14] *Bedford County Memorial Hospital, supra*, slip op. at 17-18; *Memorah Medical Center, supra*, slip op. at 10; *Lloyd Noland Hospital, supra*, 762 F.2d at 1569; *Abington Memorial Hospital, supra*, 750 F.2d at 244; *Charter Medical Corp., supra*, at 640-41. *Marshalltown Area Community Hospital*, Civ. No. 84-266-B (S.D. Iowa April 23, 1985), *Brentwood Hospital, Inc., supra*, slip op. at 16. *Mercy Medical Center, supra*, (D.Minn. Dec. 7, 1984) (final order).

the decision by the Third Circuit which applied the law in effect at the time of its decision.[15] In *Roosevelt Campobello Intern Park v. U.S.E.P.A.*, 684 F.2d 1034, 1040 (1st Cir. 1982), the EPA proposed to amend a rule but had not done so at the time of the Court's decision. The court declined to address the proposed rule "... in a hypothetical context, when it may never be necessary to do so." The court noted that after considering comments the EPA might never promulgate the amendment or that relevant court decisions may affect its determination.

Similarly, in this action there is no reason to vacate the Third Circuit judgment invalidating the malpractice rule on the basis of a proposed rule that may never be issued. If as suggested in the Petition at 11-12 the Secretary has already decided to promulgate the new rule, irrespective of the comments that she may receive, then she is conducting a sham rulemaking.[16] If the comments are carefully considered, the new rule should never be promulgated. Thus, there is no basis to vacate and remand the decision below.

The issues decided by the court below have been litigated for six years. Now, the Secretary seeks to avoid complying with the Third Circuit's decision that the providers must be reimbursed for their 1979-80 costs according to the utilization method. The Third Circuit explicitly rejected the Secretary's request as inequitable. Pet. App. 9a. Contrary to the Secretary's assertions (Pet. 11), the respondents will not receive an unwarranted windfall but rather reimbursement for costs actually incurred. In light of the unanimous decisions of the circuit courts and the overwhelming number of district court decisions invalidating the rule, and where the Third Circuit limited its award of relief to the 1979-80 fiscal year, respondents, are not

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[15] The cases cited by the Secretary (Pet. 16) that a court apply the law in effect at the time it renders its decision are irrelevant. Moreover, those same cases recognize an exception to the application of the law in effect at the time where manifest injustice may result. *See also Greene v. United States*, 376 U.S. 149, 160-61 (1964).

[16] The Secretary's recent rulemaking is an invalid attempt after the fact to buttress a defective administrative record. *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 419 (1973).

being singled out for special treatment. Moreover, in light of the lower court decisions, it is manifestly unfair to deny them reimbursement any longer.

As the Court in *Action on Smoking and Health v. CAB*, 713 F.2d at 798-99 (footnote omitted), clearly stated: "An agency cannot remedy a deficiency in one regulation by promulgating a new rule equally defective for the same or other reasons." Yet, that is precisely what the Secretary asks this Court to allow her to do. If and when a new rule is promulgated that rule will be subject to appropriate administrative challenges, and if necessary, judicial review.

The relief sought by the Secretary could create endless litigation with no resolution of the question of the amount of reimbursement to which the respondents are entitled for malpractice premiums for a cost reporting period that ended more than six years ago.[17] The Secretary's suggestion would require the same issue to be relitigated at least three times. This Court should not require the respondents to relitigate for the 1979-80 cost reporting year[18] issues on which they have already prevailed in two courts and also to litigate the same issues for subsequent cost reporting years for which the Secretary will undoubtedly contend that different considerations apply.

If and when the Secretary promulgates a new rule, and if she fails in her second chance rulemaking, should she be permitted to create a series of new records and again tie up the court system in endless litigation? In essence, this would permit the Secretary to prevent respondents from ever receiving proper reimbursement for the 1979-80 cost reporting year.[19] This is

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[17] Given that the Secretary suggests that the whole malpractice issue should be relitigated based on a new record, her professed concern for furthering the interest of "judicial economy" is illusory. Pet. 15.

[18] For these reasons we respectfully request that if this Court determines not to deny certiorari, it grant the petition and set the case for briefing and argument. *Cf.* Pet. 17, n. 14.

[19] To deny respondents reimbursement for fiscal year 1979-80 would discourage any challenge to unlawful reimbursement regulations since the plaintiffs would incur substantial litigation expenses without receiving the benefit for which they instituted the litigation.

particularly evident where, as in this case, the Secretary has not proposed to establish a new rule, but rather has proposed to "repromulgate" the same rule. 50 Fed. Reg. 25,179 (June 17, 1985).

For these reasons, even if a new rule is promulgated, to vacate the decision below is to reward the Secretary for conceding that her position in this case is not supported by the Medicare Act. By such means the Secretary could postpone indefinitely her obligation to properly reimburse respondents. This Court should reject the Secretary's request for unending litigation.

CONCLUSION

For all of the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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August 19, 1985

CERTIFICATE OF SERVICE

Civil No. 85-52

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, *et al.*

v.

ABINGTON MEMORIAL HOSPITAL, *et al.*

I, David E. Loder, a member of the Bar of this Court, certify that on August 19, 1985, I caused 3 copies of the "Brief In Opposition" to be sent by prepaid first class United States mail to the following counsel for appellees:

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Supreme Court, U.S.
FILED
SEP 10 1985
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-52 (3)

In the Supreme Court of the United States

OCTOBER TERM, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

ABINGTON MEMORIAL HOSPITAL, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

REPLY MEMORANDUM FOR THE PETITIONERS

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REPLY MEMORANDUM FOR THE PETITIONERS

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1. Subsequent to the filing of our petition for a writ of certiorari, the Fifth Circuit in *DeSoto General Hospital* v. *Heckler*, 766 F.2d 182 (1985), granted in part the Secretary's petition for rehearing and remanded the claims to the Provider Reimbursement Review Board for reconsideration in light of the Secretary's proposed new rule (App., *infra*). The disposition in *DeSoto* is thus in conflict with the decision of the Third Circuit below, as well as with decisions of the Fourth, Eighth and Eleventh Circuits, all of which have held that hospitals successfully challenging the Secretary's new formula for reimbursement of malpractice premiums are presently entitled to payment under the prior formula.[1]

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[1] *Bedford County Memorial Hospital* v. *Heckler*, No. 84-1672 (4th Cir. Aug. 14, 1985); *Menorah Medical Center* v. *Heckler*, No. 84-2257 (8th Cir. July 24, 1985); *Lloyd Noland Hospital* v. *Heckler*, 762 F.2d 1561 (11th Cir. 1985). In *Humana of Aurora, Inc.* v. *Heckler*, 753 F.2d

2. Respondents' basic argument on the remedial issue is that the Secretary's prior regulation must be held to govern their claims for reimbursement since the Secretary's attempt to amend the prior regulation has been ruled invalid.

This argument overlooks the express statutory grant of authority to the Secretary to make "suitable retroactive corrective adjustments" where the reimbursement produced by any particular formula is "inadequate or excessive." 42 U.S.C. 1395x(v)(1)(A)(ii). Thus, any present entitlement to payment under the old formula is subject to retroactive adjustment in the event the Secretary finds that the old formula produces "excessive" reimbursement. Where the Secretary has raised significant questions as to the fairness of the old formula and has instituted a rulemaking proceeding to resolve those questions, it is appropriate to withhold any order directing immediate payment of the funds in dispute under the old formula. Otherwise some hospitals will obtain payment under court judgments purporting to insulate them from recoupment under a later retroactive adjustment, while other hospitals would be subject to such an adjustment for the same cost years. Since all hospitals have known since 1979 that the old formula for Medicare reimbursement of malpractice premiums was in question and accepted Medicare patients on that basis, no unfairness is involved in waiting until the dispute is resolved before final payment is made. Respondents have already been reimbursed for the year ended June 30, 1980 under the new formula and, as our petition points out (at 9), the only amount remaining in dispute is the *difference* between reimbursement under the two formulas.

1579 (1985), petition for cert. pending, No. 85-53, the Tenth Circuit invalidated the rule and remanded the case to the district court "for further proceedings or for remand to the agency." The district court subsequently entered a judgment in favor of the hospitals for an amount certain.

The situation here bears no comparison to *NLRB* v. *Wyman-Gordon Co.*, 394 U.S. 759 (1969), as is suggested by respondents in the brief in opposition in No. 85-53. In *Wyman-Gordon*, this Court refused to remand for further proceedings, on the ground that "[t]here is not the slightest uncertainty as to the outcome of a proceeding [on remand] before the Board." 394 U.S. at 767 n.6. Here, however, the outcome of further proceedings is not certain. While the decision below rejects the Secretary's new formula on the basis of the present record, it does not address how the Secretary might proceed on a new record, nor does it prescribe other formulas the Secretary might select. Indeed, the district court in this case, in an opinion that the court of appeals adopted, refused to "specify what method of apportioning malpractice insurance costs should be adopted." Pet. App. 26a-27a. In contrast, orders directing payment under the old formula will have the practical effect of specifying "what method of apportioning malpractice insurance costs" will govern for the hospitals and costs years involved in these cases. That would be an inappropriate disposition, particularly in light of the Secretary's ongoing efforts to comply with the statute in an evenhanded manner.

For these reasons and the reasons stated in our petition, certiorari should be granted, the judgment of the court of appeals should be vacated, and the case should be remanded for further proceedings.

Respectfully submitted.

LAWRENCE G. WALLACE*
Acting Solicitor General

SEPTEMBER 1985

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*Acting Solicitor General Fried is disqualified in this case.

APPENDIX

DESOTO GENERAL HOSPITAL, et al.,
Plaintiffs-Appellees,

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANTS-APPELLANTS

No. 84-3577

United States Court of Appeals, Fifth Circuit.

Aug. 19, 1985

Appeal from the United States District Court
for the Middle District of Louisiana,
Frank J. Polozola, Judge.

ON PETITION FOR REHEARING

(Opinion of July 5, 1985, 5th Cir.
1985, 766 F.2d 182).

Before GARZA, POLITZ and DAVIS, Circuit Judges.

PER CURIAM:

The Secretary of Health and Human Services petitions for rehearing, asking that resolution of this appeal be held in abeyance pending disposition of pending petitions for certiorari in *Abington Memorial Hospital* v. *Heckler*, 750 F.2d 242 (3d Cir. 1984), and *Humana of Aurora, Inc.* v. *Heckler*, 753 F.2d 1579 (10th Cir. 1985). We decline to do so.

The Secretary alternatively requests that we vacate that portion of our opinion modifying the judgment of the district court and directing the reimbursement of the appellee-hospitals "pursuant to 42 C.F.R. § 405.452(b)(1) (1979), without reference to the abrogated malpractice rule." The Secretary urges a remand to the Provider Reimbursement

Review Board for appropriate action, specifically, reconsideration under a proposed new rule affecting malpractice insurance premium reimbursement. *See* 50 Fed. Reg. 25178 (June 17, 1985). This alternative suggestion is meritorious.

The petition for rehearing is granted in part and appellees' claims are remanded to the PRRB for reconsideration in light of relevant changes occurring after the Board's initial rulings herein. In all other respects the petition for rehearing is denied and our original opinion is reconfirmed.